Ministry of Health

Annual Report for 2016-17

saskatchewan.ca

Government of Saskatchewan

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Letters of Transmittal

The Honourable
Jim Reiter
Minister of Health

The Honourable
Greg Ottenbreit
Minister Responsible for Rural and Remote Health

July 29, 2017

Her Honour, the Honourable Vaughn Solomon Schofield
Lieutenant Governor of Saskatchewan

May it Please Your Honour:

We respectfully submit the Annual Report of the Ministry of Health for the fiscal year ending March 31, 2017.

The Government Direction and Budget for 2016-17 invested in people and infrastructure to Keep Saskatchewan Strong, and led transformational change across government to ensure the sustainability of high quality public services delivered in the most effective and efficient way possible.

In 2016-17, funding and resources in the Ministry of Health and in the health system focused on providing better access to services and improving the quality and responsiveness of care for Saskatchewan residents. This focus included improvements in primary health care, specialist referrals, diagnostics, mental health and addictions, long term care, home care and acute care.

In 2016-17 efforts reduced emergency department waits and improved patient flow across the health system. Research has shown that long waits in the emergency room are a symptom of multiple challenges across the entire continuum of care. The health system is responding with services to address gaps in mental health and addictions services and supports for seniors that may have in the past brought residents to emergency rooms for care they haven't received in the community. Hospital overcrowding also has a direct impact on delays in emergency rooms. Solutions to obstacles like these require a system wide approach aimed at improving each phase of the patient's journey.

We also pursued improvements in other key areas such as appropriateness of care, protecting core health services and promoting a culture of safety in which patients and staff experience no harm.

In the fall of 2016 a three person Advisory Panel on Health System Structure consulted with citizens, stakeholders and providers. They also received over 300 written submissions through an online form and by mail. On January 4, 2017, the Advisory Panel presented their report to government and all recommendations were accepted. Preliminary planning began in the final quarter of 2016-17 for the consolidation of the twelve regional health authorities into one single Provincial Health Authority in 2017-18 and delivering services more efficiently.

This annual report reflects the health system's progress towards these areas and more in 2016-17.

Sincerely,

Jim Reiter
Minister of Health

Greg Ottenbreit
Minister Responsible for Rural and Remote Health

Max Hendricks
Deputy Minister of Health

July 29, 2017

His Honour, the Honourable Jim Reiter, Minister of Health and
His Honour, the Honourable Greg Ottenbreit, Minister Responsible for Rural and Remote Health

May it Please Your Honours:

I have the honour of submitting the Ministry of Health annual report for the fiscal year ending March 31, 2017. The information contained in this report is, to the best of my knowledge, accurate and reliable.

The health system's goals in 2016-17 were to improve patients and families' access to care and reduce emergency room waits. Achieving these goals required focus on interrelated challenges across the whole continuum of care.

This report describes how the Ministry and our health care partners worked to improve the experience of patients and families in a number of areas including: primary health care, long term care and home care, as well as access to specialists' appointments and mental health and addictions services.

Max Hendricks
Deputy Minister of Health

Introduction

This annual report for the Ministry of Health presents the Ministry's results for the fiscal year ending March 31, 2017. It provides results of public commitments, key actions and performance measures identified in the Ministry of Health Plan for 2016-17. It also reflects progress toward commitments from the Government Direction for 2016-17: Keeping Saskatchewan Strong, the *Saskatchewan Plan for Growth – Vision 2020 and Beyond*, and throne speeches.

The annual report demonstrates the Ministry's commitment to effective public performance reporting, transparency and accountability to the public.

Alignment with Government's Direction

The Ministry's activities in 2016-17 align with Government's vision and four goals:

Saskatchewan's Vision

"... to be the best place in Canada – to live, to work, to start a business, to get an education, to raise a family and to build a life."

- **Sustaining growth and opportunities for Saskatchewan people**
- **Meeting the challenges of growth**
- **Securing a better quality of life for all Saskatchewan people**
- **Delivering responsive and responsible government**

Government's vision and four goals provide the framework for ministries, agencies and third parties to align their programs and services and meet the needs of Saskatchewan's citizens.

Ministry Overview

Mandate Statement

Through leadership and partnership, the Ministry of Health is dedicated to achieving a responsive, integrated and efficient health system that puts the patient first, and enables people to achieve their best possible health by promoting healthy choices and responsible self-care.

Mission Statement

The Saskatchewan health care system works together with you to achieve your best possible care, experience and health.

Ministry Role

The Ministry of Health strives to explore innovative approaches and set bold targets for the health system in four areas: better health, better care, better value, and better teams. Our system-wide focus on quality improvement puts the needs and values of patients and families at the forefront of both our planning and the delivery of care.

The strategic work of the Ministry detailed in this report is organized into four areas called the Betters in the 2016-17 Health Plan. Each of the "betters" as well as the health system's vision, mission, and values are reflected in figure 1. The Betters are:

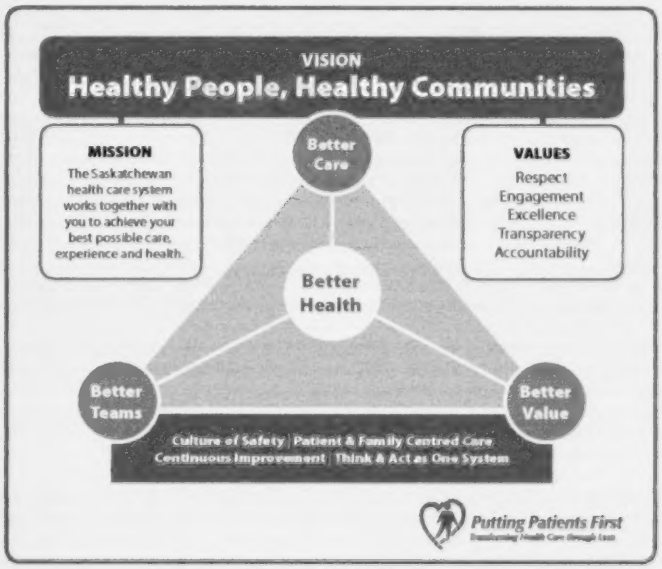

Figure 1: Health System Strategic Direction

Better Health - Improve population health through health promotion, protection, and disease management/prevention, and collaborating with communities and other provincial and federal government organizations to close the health disparity gap.

Better Care - In partnership with patients and families, improve the individual's experience, achieve timely access, and continuously improve health care safety.

Better Value - Achieve best value for money, improve transparency and accountability, and strategically invest in facilities, equipment and information infrastructure.

Better Teams - Build safe, supportive workplaces where providers are focused on patient- and family-centred care and collaborative practices, and develop a highly skilled, professional, and diverse workforce that has a sufficient number and mix of service providers.

The Ministry of Health:

- Provides leadership on strategic policy;
- Sets goals and objectives for the provision of health services;
- Allocates funding and leads financial planning for the health system;
- Provides provincial oversight for programs and services, including acute and emergency care, community services, and long term care;
- Monitors and enforces standards in privately delivered programs such as personal care homes;
- Administers public health insurance programs such as the Saskatchewan Medical Care Insurance Plan;
- Provides eligible residents with prescription drug plan benefits and extended health benefits, including: Supplementary Health, Family Health Benefits, and Saskatchewan Aids to Independent Living (SAIL);
- Provides communicable disease surveillance, prevention, and control through the Saskatchewan Disease Control Laboratory and Population Health Branch to identify, respond to, and prevent illness and disease in our province;
- Provides leadership on health human resource issues; and,
- Has leadership on and responsibility for approximately 50 different pieces of legislation. (See Appendix IV on page 51).

The health care system in Saskatchewan is multi-faceted and complex and is composed of 12 health regions (see figure 2), the Saskatchewan Cancer Agency, the Athabasca Health Authority, affiliated health care organizations, and a diverse group of professionals, many of whom are in private practice. There are 26 self-regulated health professions in the province and the health system as a whole employs more than 42,000 people who provide a broad range of services.

The Ministry assists health regions, the Saskatchewan Cancer Agency, and other stakeholders to recruit and retain health care providers, including nurses and physicians. The Ministry also works in partnership with organizations at local, regional, provincial, national, and international levels to provide Saskatchewan residents with access to quality health care.

The Ministry supports the *Saskatchewan Plan for Growth* and is helping to ensure an estimated 1.2 million provincial residents in the year 2020 enjoy a better quality of life by:

- Undertaking continuous quality improvements in the delivery of programs and services through the use of continuous improvement, and other methods and tools. This includes program review, an ongoing process to ensure the programs and services delivered by government are being delivered as efficiently and effectively as possible, as well as being aligned to government's priorities.
- Requiring third parties that receive significant provincial funding such as health regions, to demonstrate financial efficiencies through, for example, joint supply purchasing, shared services, and continuous improvement initiatives.

In Canada, the federal and provincial governments both play a role in the provision of health care. The federal government provides funding to support health through the Canada Health Transfer. The federal government also provides health services to certain segments of the population (e.g. veterans, military personnel, and First Nations people living on reserve). Provincial governments are responsible for most other aspects of health care delivery.

In 2016-17, the Ministry employed 508.1 full time equivalent staff (FTEs), 11.2 FTEs greater than its 496.9 FTE budget. The variance was primarily the result of employing more students.

A complete listing of all publications produced by the Ministry of Health can be found at: www.saskatchewan.ca

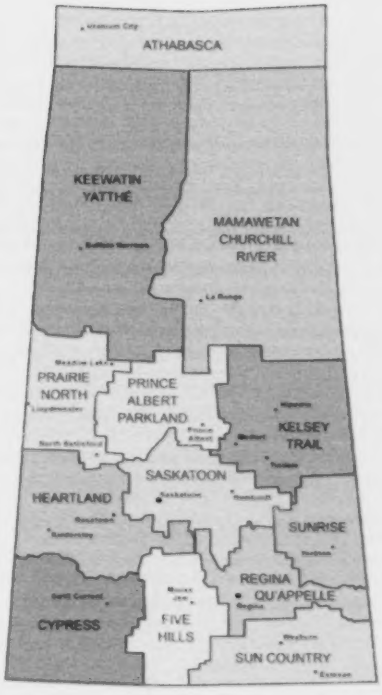

Figure 2: Regional Health Authorities

The Public Interest Disclosure Act

The Government of Saskatchewan and the Ministry of Health are committed to accountability, trust, and protecting the public interest as well as maintaining high standards of professional values and ethics in the Public Service.

The *Public Interest Disclosure Act* was proclaimed in 2011 to support these commitments. The Act helps to maintain the integrity of government and the Public Service, and supports accountability and fairness. The Act also sets up a structure under which public servants can report allegations of wrongdoing within the Public Service and protects those who make reports.

The Ministry did not receive any disclosures in 2016-17.

Progress in 2016-17

Better Health

Government Goals

Sustaining growth and opportunities for Saskatchewan people	Meeting the challenges of growth	Securing a better quality of life for all Saskatchewan people	Delivering responsive and responsible government

These actions support the Saskatchewan Plan for Growth with Better Care

Ministry Goal

In partnership with patients and families, improve the individual's experience, achieve timely access and continuously improve health care safety.

Emergency Department Waits and Patient Flow

Existing efforts to reduce emergency department waits across the health system continued in 2016-17. Reducing emergency department waits and improving patient flow remains a key priority.

Patients across the province continue to wait too long for care in emergency departments. A complex set of problems which span the health system lead to these long waits.

Access to timely care in the community continues to be a barrier for many patients, resulting in emergency department visits being their default option. When patients arrive at an emergency department, they are assessed using a tool called the Canadian Triage and Acuity Scale (CTAS) system. The CTAS system prioritizes patients and scores them on a scale of one (most urgent) to five (least urgent), ensuring that those patients requiring urgent care will receive care on a priority basis. Level four or five care is also available in physician clinics.

Key Actions and Results

Develop a cross functional planning strategy

Cross functional planning is defined as "planning seamlessly across various organizations and programs within the health system from the perspective of the patient and family". Throughout 2016-17, this planning and associated health system modeling were used to develop a system-wide *Connected Care Strategy* for 2017-18 to address emergency department wait times and improve patient flow.

Support health regions with implementation of Alternate Level of Care and Interdisciplinary Rounds strategies at the point of care.

In 2016-17, focused coaching support was provided to assist all regions with rolling out Alternate Level of Care (ALC) and Interdisciplinary Rounds (IDR) strategies.

Interdisciplinary Rounds

During IDR members of a patient's health care team come together at the same time with the patient, and their family if possible, to discuss their care. The healthcare team includes the physician, nursing, and the interprofessional practice team which may include physiotherapy, occupational therapy, social work, pharmacy, registered dieticians, and speech language pathology.

The difference with IDR is it takes the discussion of the patient's care to the beside to include the patient. Recently, the Health Quality Council created a toolkit to bring greater standardization to these rounds as part of the plan to reduce emergency wait times. Evidence has shown that participation in regular IDR improves patient flow and the patient experience. They are also a core feature of an accountable care system, which is being implemented throughout the province as part of the Ministry of Health's commitment to improve emergency department wait times.

Daily IDR can vary from just a few minutes to almost 30 minutes per patient, depending on the complexity of patient needs. They are done regularly to ensure everyone, including the patient's family, is on the same page to reduce any gaps in communication.

Alternate Level of Care (ALC)

An ALC patient is a patient who in a facility and does not require the intensity of resource and/or services provided in that care setting.

All regions continue to progress in improving the quality of IDR, including having all of the necessary team members participate. Coaching support has been ongoing, and it is anticipated that support will continue in 2017-18 to entrench these practices in all facilities.

The Initiative Team, along with all provincial health regions, continues to work on the identification and designation of ALC patients in acute care. The goal had been to create a system to identify all ALC patients by the end of 2016-17. As of March 31, 2017, ten health regions were submitting ALC data to the provincial dashboard; the remaining two health regions anticipate submitting data by June 1, 2017.

In the long term, identifying and classifying patients as ALC will help us provide better health care. It will show us where there are gaps in service and inform the decisions we make regarding the allocation of resources. It will improve the flow of patients through the health care system. It will reduce wait times in the emergency department. But most importantly, it will support patients in receiving the care that meets their needs.

Performance Measures

Figure 3: Efforts to reduce emergency department waits and improve patient flow across the health system.

	Average of 2015-2016 90th percentile	Average of 2016-2017+ 90th percentile	Target	Success
By March 31, 2017 there will be 35 per cent reduction in wait time targets measured from the 2013-14 baselines (average of 2013-14 90th percentile).	Emergency Department Length of Stay Admitted: 3 per cent higher than baseline Emergency Department Length of Stay Non-Admitted: 4 per cent higher than baseline Time Waiting For an Inpatient Bed: 3 per cent lower than baseline	Emergency Department Length of Stay Admitted: 11 per cent higher than baseline Emergency Department Length of Stay Non-Admitted: 4 per cent higher than baseline Time Waiting For an Inpatient Bed: 4 per cent higher than baseline	35 per cent reduction from 2013-14 baselines	Not achieved.
By March 31, 2017, 100 per cent of all Medical/ Surgical and Critical Care Units will have implemented interdisciplinary physician attended bedside rounds in Provincial and Regional hospitals.	57 per cent implemented to some degree*	78 per cent implemented to some degree*	100 per cent implementation	Partially achieved.
By March 31, 2017, Alternate Level of Care data will be captured in 100 per cent of adult units in hospitals across Saskatchewan.	5 units submitted ALC data (an estimated 5 per cent of units)	81 units submitted ALC data to provincial dashboard (an estimated 76 per cent of units)^	Alternate Level of Care data captured in 100 per cent of adult hospital units	Partially achieved. Not all regions collecting data.

+ data to end of February 2017.

Notes for Figure 3

* *The language of "to some degree" reflects the continuous improvement required to fully implement interdisciplinary physician attended bedside rounds. Units may have "implemented" IDR, but are working to improve the level of patient family engagement.*

^ *Due to incomplete reporting of total number of units, it is difficult to determine the denominator for this metric.*

Health Promotion, Disease Prevention

Ministry Goal

Improve population health through health promotion, protection and disease prevention, and collaborating with communities and different government organizations to close the health disparity gap.

Key Actions and Results

Expansion of Human Papillomavirus Vaccination Program

The province is committed to cancer prevention and announced the expansion of the human papillomavirus (HPV) vaccination program to include boys, starting in September 2017. This is a significant investment in the current and future health and well-being of all children. Over 11,000 doses of the vaccine were administered to girls by Public Health Nurses through the school program in 2015-16.

HIV & AIDS in Saskatchewan
Progress 2009-2016
$4M
This funding supports:
additional staff to deliver services
community based programs
more prevention & risk reduction programs
training and education opportunities
peer supports & outreach
Progress since 2009
Over 30 full time HIV care & support staff
57% increase in HIV testing
Prevention & risk reduction programs in 27 sites
Say "YES!" to the Test
HIV testing policy
Infant Formula Program
Public awareness
Testing in more locations
Training & mentorship opportunities
Peer-to-peer programs in 6 health regions
Surveillance & research activities
Policies & guidelines

Figure 4: Supports for Patients with human immunodeficiency virus and Aids in Saskatchewan.

There are more than 100 different types of HPV, and around 25 are known to or suspected of causing cancer. It is estimated that 75 per cent of adults will develop an infection during their lifetime; most will never know they have been infected as there are no symptoms. Widespread immunity to HPV is important to prevent future HPV-related cancers.

Reduce Human Immunodeficiency Virus (HIV) Rates

Saskatchewan's Human Immunodeficiency Virus (HIV) rates increased from 2006 to 2009 then declined to 2014. An increase again occurred in 2015 with 160 cases and in 2016 with 170 cases (preliminary data). Injection drug use and sexual contact are the reported risk factors. Over the past ten years, the mean age of the cases has slowly increased from 32.8 years to 39.8 years. Testing is also an important too in reducing HIV rates in the province. The number of HIV tests performed by the Saskatchewan Disease Control Laboratory in Regina increased 57 per cent between 2009 and 2016.

In October more than 180 stakeholders including people living with HIV, physicians, nurses, health region HIV coordinators, Indigenous leaders, community based organizations, provincial Ministries and the federal government met at "Sharing the Wisdom" in Saskatoon. The purpose of this meeting was to provide a forum for collaboration and information sharing among provincial stakeholders and gather input into a multiyear provincial work plan that will guide HIV reduction work in the province. The work plan they developed builds on the framework and activities implemented since the 2010-2014 provincial HIV Strategy. The work plan is based on four pillars: 1. Community engagement and education, 2. prevention and harm reduction, 3. clinical management and 4. surveillance and research. It also includes supports for other communicable diseases such as tuberculosis, hepatitis C and sexually transmitted infections.

West Nile Virus Reporting

West Nile Virus is an annual risk for Saskatchewan residents between June and September, with the highest risk in the southern part of the province. West Nile Virus activity in 2016 was sporadic. Infected mosquitoes and horses were detected in a few localized areas. Cool rainy weather in July and August produced an abundance of mosquitoes, but significantly reduced transmission of the virus from the Culex tarsalis mosquito that carries West Nile Virus. There were no Saskatchewan human neuroinvasive cases reported in 2016.

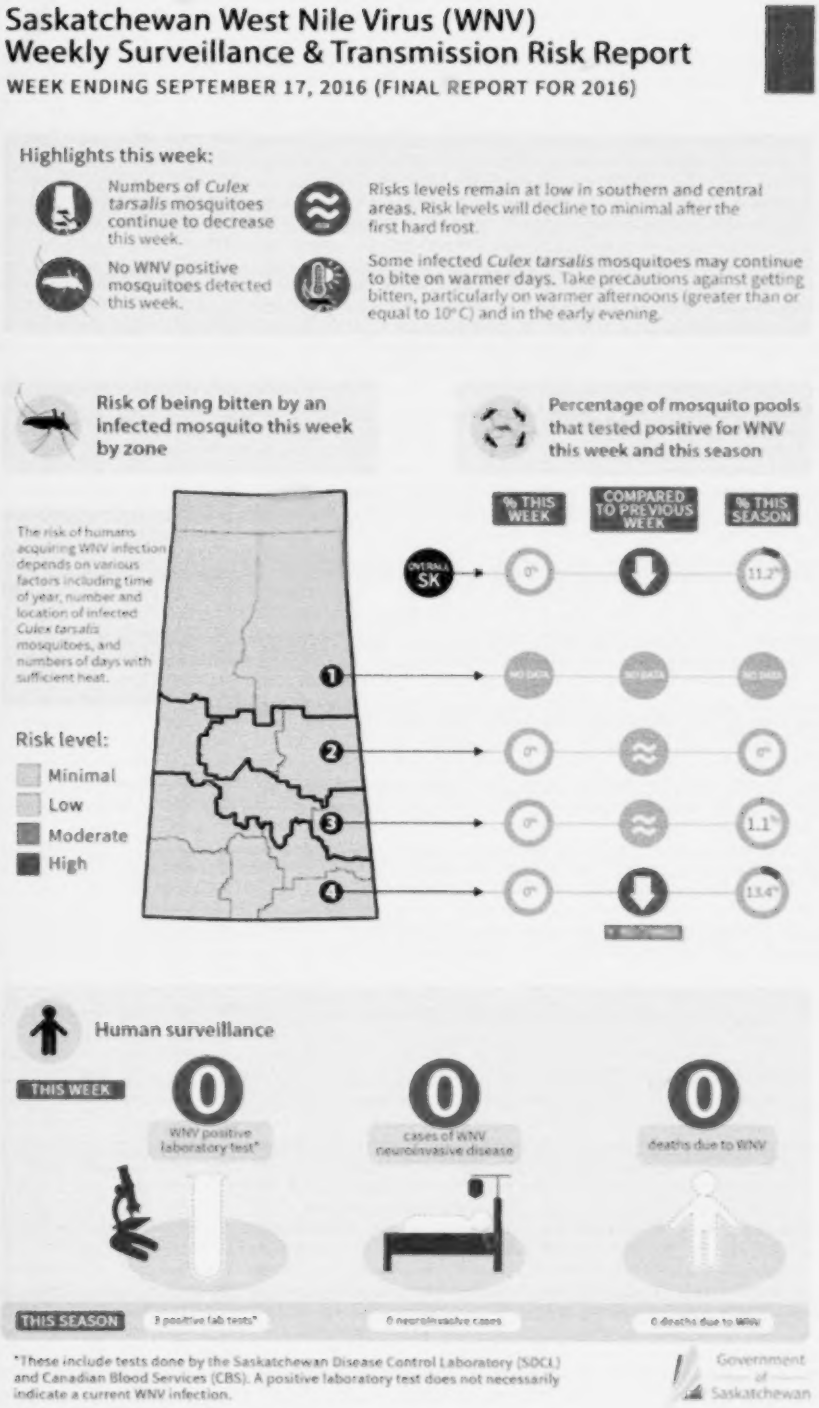
Saskatchewan West Nile Virus (WNV)
Weekly Surveillance & Transmission Risk Report
WEEK ENDING SEPTEMBER 17, 2016 (FINAL REPORT FOR 2016)
Highlights this week:
Numbers of Culex tarsalis mosquitoes continue to decrease this week.
Risks levels remain at low in southern and central areas. Risk levels will decline to minimal after the first hard frost.
No WNV positive mosquitoes detected this week.
Some infected Culex tarsalis mosquitoes may continue to bite on warmer days. Take precautions against getting bitten, particularly on warmer afternoons (greater than or equal to 10°C) and in the early evening.
Risk of being bitten by an infected mosquito this week by zone
Percentage of mosquito pools that tested positive for WNV this week and this season
The risk of humans acquiring WNV infection depends on various factors including time of year, number and location of infected Culex tarsalis mosquitoes, and numbers of days with sufficient heat.
Risk level:
Minimal
Low
Moderate
High
% THIS WEEK
COMPARED TO PREVIOUS WEEK
% THIS SEASON
OVERALL SK
0%
11.2%
NO DATA
0%
1.1%
13.4%
Human surveillance
THIS WEEK
0
WNV positive laboratory test*
0
cases of WNV neuroinvasive disease
0
deaths due to WNV
THIS SEASON
3 positive lab tests*
0 neuroinvasive cases
0 deaths due to WNV
*These include tests done by the Saskatchewan Disease Control Laboratory (SDCL) and Canadian Blood Services (CBS). A positive laboratory test does not necessarily indicate a current WNV infection.
Government of Saskatchewan

Figure 5: Saskatchewan West Nile Virus (WNV) Summer 2016 Surveillance and Transmission Risk Report

Figure 5 is a summary of West Nile Virus surveillance and transmission risk reports posted each week on Saskatchewan.ca in 2016.

Government Goals

Sustaining growth and opportunities for Saskatchewan people	Meeting the challenges of growth	Securing a better quality of life for all Saskatchewan people	Delivering responsive and responsible government

These actions support the Saskatchewan Plan for Growth with Better Care

Referral to Specialists and Diagnostics

The strategies and results listed in this section assisted the province to reduce the wait time for an appropriate first consult appointment with a specialist by 50 per cent in eight to 10 specialty groups by March 31, 2019.

Key Actions and Results

Implement the Provincial Model for an Appropriate Referral to a Specialist

Two clinical groups are currently using the provincial referral model for an appropriate referral to a specialist: the Regina Hip and Knee Treatment and Research Centre (HKTRC, and Regina Mental Health Clinic, representing mental health services. Both groups have demonstrated a reduction in the wait time to see a specialist and have improved patient and provider satisfaction with the new processes.

- Regina HKTRC reported a 78 per cent reduction in its wait time from nine months to two months compared to their baseline data.
- In its first year, Regina Mental Health Clinic reported a reduction in its wait time from 86 days to 53 days (a 38 per cent reduction from baseline data).

Expand the LINK Telephone Consult Service for Non-Urgent Telephone Consultations

LINK (Leveraging Immediate Non-urgent Knowledge) is a provincial telephone consultation service. When primary care physicians use LINK their patients can receive immediate access to specialist experts, within the convenience of a primary care visit.

The service provides access to a specialist's advice about referrals, treatments, diagnosis and prescriptions while the patient is still in the primary care physician's office. Physicians that have used LINK report:

- 54 per cent of LINK calls avoided a referral to a specialist, and
- 39 per cent of calls avoided an emergency department visit.

Specialists should notice they receive more appropriate referrals.

Adult Psychiatry is the first group to participate in this service (since February 2016). Two additional specialties have been recruited in efforts to expand LINK. Geriatric Psychiatry and Palliative Care physicians are expected to start taking calls by the end of 2017. See figure 6.

Use of Generic Referral Letters and Consult Notes Improves Patient Care

The College of Physicians and Surgeons of Saskatchewan, Senior Medical Officers and the Saskatchewan Medical Association have endorsed the use of generic referral letters and consult notes, as developed by College of Family Physicians of Canada and Royal College of Physicians and Surgeons. These generic letters ensure that the right information is being shared in physician-to-physician communications.

Implement the Provincial Referral Model with a Specialty Utilizing Advanced Medical Imaging

The Ministry has met with specialists that use advanced diagnostic imaging (e.g. MRI and CT) about adopting the Provincial Referral Model. There is preliminary interest in proceeding and discussions continue with the goal of developing a plan with stakeholders to begin this work in 2017-18. See figure 7.

Figure 6: Expansion of the LINK Telephone Consult Service for non-urgent telephone consultations.

	March 2016	March 2017	Target	Success
Expand the LINK Telephone Consult Service for non-urgent telephone consultations in two to three more specialties.	One specialty group providing LINK services (Adult Psychiatry).	Implementation in progress.	Two to three more specialties	In progress.

Figure 7: Progress on measures to reduce the wait time for an appropriate first consult appointment with a specialist by 50 per cent in eight to 10 specialty groups by March 31, 2019.

	March 2016	March 2017	Target	Success
Implement the provincial model for an appropriate referral to a specialist with two to three new specialty groups.	Provincial referral model implemented - Regina Hip & Knee Treatment and Research Centre	Provincial referral model implemented - Regina Mental Health Clinic. Implementation in progress - Provincial Rheumatology.	Provincial referral model implemented in two to three specialty groups.	Partially achieved
Begin to automate the provincial referral model into the provincial Electronic Medical Record systems.	No standardized automation of the referral process.	Generic templates for referral letter and consult note are being added to provincial EMRs.	One component of the provincial referral model is automated in the provincial EMR systems.	Achieved
Implement the provincial referral model with a specialty utilizing advanced medical imaging (MRI, CT)	None implemented	None implemented	Provincial referral model implemented in one specialty group utilizing advanced medical imaging.	Not achieved

Private MRI and CT Services

On February 28, 2017, *The Patient Choice Medical Imaging Act* and supporting regulations were proclaimed. This enables licensed private MRI or CT facilities the opportunity to accept payment directly from patients in exchange for MRI and CT services, while ensuring there is also an extended benefit to the public system. Under the unique to Saskatchewan "two-for-one provision", licensees are required to provide a second scan, free of charge, to an individual waiting on the public list every time a person chooses to pay privately for an MRI or CT service. See figure 8.

Figure 8: Progress on reducing the wait time for an appropriate first consult appointment with a specialist by 50 per cent in eight to 10 specialty groups by March 31, 2019.

	March 2016	March 2017	Target	Success
Introduction of legislation that would enable private-pay CT services.	Similar legislation passed for private-pay MRI services.	The legislation was introduced for private-pay CT services.	Legislation introduced in 2016-17	Achieved. Legislation proclaimed February 28, 2017

Performance Measures

Figure 9: Implementation of the provincial referral model for an appropriate referral to specialist with two to three new specialty groups.

	March 2016	March 2017	Target	Success
Achieve a 25 per cent improvement in wait times in the first year (Regina Adult Psychiatry and Mental Health Clinic)	Wait time of 86 days as of April 2015 (baseline); no data available for March 2016.	53 days (38 per cent reduction in wait times)	25 per cent reduction in wait times	Achieved
Achieve another 25 per cent improvement in the second year (Regina HKTRC).	Nine months as of 2014-15 (baseline).	Two months (78 per cent reduction in wait times)	25 per cent reduction in wait times (combined 50 per cent over two years)	Achieved

Appropriateness of Care

Appropriate care is defined by the Canadian Medical Association as: *"the right care, provided by the right providers, to the right patient, in the right place, at the right time, resulting in optimal care."* The Ministry of Health's 2009 *Patient First Review, For Patients' Sake*, indicated that at times patients in Saskatchewan may not receive the best treatment options – or appropriate care – for a variety of reasons.

Some of these reasons include availability of services, access to care, variation in physician practices, and lack of solid evidence available for physicians to support the best treatment options. This can lead to uncertainty and variation in decision-making. All of these factors impact the appropriateness of care that patients, clients and residents receive and contribute to underuse, overuse, misuse and variation in services and, consequently, inappropriate care.

The Saskatchewan health system is committed to addressing these issues through the implementation of a provincial *Appropriateness of Care Framework*. This framework is designed to support physicians, health care providers, patients, and families in an effort to improve appropriateness of care throughout the health system. Learn more Appropriateness of Care about by watching this video produced by the Cypress Health Region. *Choosing Wisely in the Cypress Health Region*

By March 31, 2018, 80 per cent of clinicians in at least three selected clinical areas will be utilizing agreed upon best practices from the *Appropriateness of Care Framework*.

Key Actions and Results

Appropriateness of Medical Imaging Tests Ordered for Patients with Low Back Pain

Improving appropriateness of medical imaging tests ordered for patients with low back pain, specifically Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans, and reducing duplication of tests, is being achieved as follows:

- The number of requests for lumbar spine MRIs in Regina Qu'Appelle and Saskatoon Health Reg continues to decline since the Appropriateness of Care (AC) Framework, which outlines a standard approach for improving clinical appropriateness, was tested using Lumbar Spine MRI as the clinical example was introduced in late 2015. Implementation of a simple checklist, which provides best practice indications for ordering lumbar spine MRIs, resulted in a 32 per cent decrease in requests for lumbar spine MRI in the ten months following the implementation.
- The AC Framework methodology was replicated for the Lumbar Spine CT project, with the formation of a Clinical Development Team (orthopedic surgeons, neurosurgeons, family physicians, a chiropractor, and patient and family advisors). The key goals of this project are to improve appropriate ordering of lumbar spine CTs and reduce duplicate testing between CT and MRI for low back pain. Data indicates that about 10-15 per cent of patients who received a lumbar spine MRI also received CT a year prior to having an MRI.
- The Clinical Development Team developed a checklist, which includes best practices for ordering a lumbar spine CT scan. The checklist will be trialed in four health regions (Regina Qu'Appelle, Saskatoon, Prairie North, and Five Hills) from April 2017 to July 2017. After data obtained during the trial period is analyzed, the checklist will be revised based on feedback received from physicians. The finalized checklist will be implemented provincially in 2017-18.
- The trial of the CT Lumbar Spine checklist was scheduled to be completed before the end of 2016-17 but was delayed due to a lack of capacity in the health regions to collect and analyze data. The Ministry of Health allocated funding to three health regions in January 2017 to enhance their capacity for data analytics and measurement for supporting Appropriateness of Care projects.

Performance Measures

Figure 10: Percentage of physicians ordering lumbar spine CT scan utilize/comply with the agreed upon best practices.

	March 2016	March 2017	Target	Success
By March 31, 2017, 80 per cent of physicians ordering lumbar spine CT scan utilize/comply with using the CT Lumbar Spine checklist.	Unavailable*	Unavailable*	80 per cent	Not achieved

** Physician adherence with the CT Lumbar Spine checklist will be used as an indicator for measuring this target; however, data is not available to report due to the delay in the trial of the checklist. This measure will be reported in the 2017-18 Annual Report.*

Improving Health System Capacity to Improve Appropriateness of Care

The provincial Appropriateness of Care program team has been working collaboratively with health system partners, including health regions (RHAs), the Saskatchewan Cancer Agency (SCA), the Health Quality Council (HQC), and the Saskatchewan Medical Association (SMA), to build the system's capacity for physicians to lead clinical quality improvement work, which is directly linked to improving appropriateness of care (AC).

The AC Network was formally launched on September 30, 2016, with membership including AC leads (physician leads, Vice Presidents of Quality and Safety, Quality Improvement Directors) from individual health regions, SCA, HQC, eHealth Saskatchewan, SMA, as well as patient advisors. It will be the key operational arm for advancing AC in Saskatchewan.

The provincial AC Program Team has been working closely with the SMA to align provincial and regional AC work with Choosing Wisely Canada (CWC), a campaign launched in April 2014 by the Canadian Medical Association to reduce unnecessary medical tests, treatments and procedures. A regional CWC coordinator position funded by CWC has been located in HQC. This position will work closely with the provincial AC Program Team and the AC Network to align provincial efforts to improving AC with CWC recommendations and guidelines.

Appropriateness of Care Education and Training Programs

Through the collaborative efforts of the SMA, HQC, the provincial AC Program team and the Ministry of Health, two streams of educational opportunities for physicians interested in leading and participating in clinical quality improvement work have been developed. Physician participants in both streams are required to lead an AC project and will be paired with a physician-coach whose role is to provide support and guidance to the participants throughout the program.

1. The Clinical Quality Improvement Program (CQIP) is a formal educational program designed to improve participant's knowledge of clinical quality improvement methodology. The program was developed by HQC, using content adapted from a renowned program in Intermountain Health in Salt Lake City, Utah. It formally launched in late 2016 and will run until November 2017. A total of 16 physicians from five health regions, SCA and the University of Saskatchewan were selected to participate in the first cohort. These physicians represent a variety of medical practices including family medicine, pediatrics, psychiatry, hospital medicine, surgery, radiology, pathology and radiation oncology. CQIP has been approved as an accredited program for physicians to accrue Continuing Medical Education credits.
2. The SMA Appropriateness of Care Initiative (SACI) is an informal training program designed to provide an opportunity for physicians who are not enrolled in CQIP, but have an interest in developing and implementing their own clinical quality improvement projects. The vision for SACI is that physicians who participate may be future candidates for CQIP. The final process details for this stream of quality improvement work are being developed, with a pilot underway in Saskatoon Health Region.

Removing Barriers for Measuring the Outcomes of Appropriateness of Care Projects

During the meetings with health region CEOs and their senior leadership teams in June 2016, the health regions identified two key barriers to improving clinical quality improvement:

- Limited capacity to access appropriate data and
- Insufficient human resources with the skillset and knowledge for data collection and measurement support.

To address the data and measurement barrier, the Ministry of Health provided funding to three health regions (Regina Qu'Appelle, Saskatoon and Prairie North) to hire data analysts to provide support for physicians participating in CQIP and SACI, as well as provincial and regional AC projects. The data analyst positions in these three regions will also provide support to physicians in surrounding regions.

Government Goals

Sustaining growth and opportunities for Saskatchewan people	Meeting the challenges of growth	Securing a better quality of life for all Saskatchewan people	Delivering responsive and responsible government

These actions support the Saskatchewan Plan for Growth with Better Health

Mental Health and Addictions

By March 2019, there will be increased access to quality mental health and addiction services and reduced wait times for outpatient and psychiatry services.

Key Actions and Results

Figure 11: Number of health regions implementing a framework to match client needs to the most appropriate mental health and addiction service e.g. Stepped Care (with the support of the Ministry of Health).

	Health regions using the Level of Care Utilization System (LOCUS) 2015-16	Health regions using LOCUS 2016-17	Target	Results
Health regions implement a tool to match client needs to the most appropriate mental health and addiction service	A provincial integrated client record did not exist.	Health regions participated in the strategic planning to introduce a stepped care framework that initially focused on the implementation of LOCUS in a provincial client record.	All health regions participate in planning for the implementation of LOCUS in a provincial client record.	Achieved

Patients and clients are matched with the most appropriate mental health and addiction service by:

1. Introduction of standard provincial intakes (with triage thresholds) and primary assessments;
2. Caseload reviews and policies to reduce no shows;
3. Implementation of stepped care approaches which match service intensity to client needs through lower intensity interventions such as Internet-based Cognitive Behavioural Therapy (I-CBT), group services, and single session walk-in treatment; and,
4. The development of an electronic client information system that assesses and matches level of care needs to existing services using the Level of Care Utilization System (LOCUS) tool.

Performance Measures

Significant process has been achieved on reducing wait times for outpatient mental health and addiction services. In 2016-17, the health regions increased their targets to meet benchmark targets 100 per cent of the time. Health regions reported on this targeted monthly and made corrective action plans when targets were not met. It is important to note that very small numbers affect the overall percentage (e.g., one client not being served within the benchmark triage time results in not meeting the target) and that the majority of individuals are seen within the targets.

Figure 12: Wait times for outpatient mental health and addiction services measured at all levels of urgency – Triage Benchmarks

By March 31, 2017, meet triage benchmarks for outpatient mental health & addiction services 100 per cent of the time	Percentage meeting benchmarks March 2016	Percentage meeting benchmarks March 2017	Target	Results
Mental Health – Adult*	13 of 13 health regions met the 85 per cent benchmark.	10 of 13 health regions met the 100 per cent benchmark.	100 per cent	Partially achieved
Mental Health – Child and Youth*	9 of 13 health regions met the 85 per cent benchmark.	8 of 13 health regions met the 100 per cent benchmark.	100 per cent	Partially achieved
Addictions – Adult*	13 of 13 health regions met the 85 per cent benchmark.	10 of 13 health regions met the 100 per cent benchmark.	100 per cent	Partially achieved
Additions – Youth*	13 of 13 health regions met the 85 per cent benchmark.	10 of 13 health regions met the 100 per cent benchmark.	100 per cent	Partially achieved

* It is important to note that the Regina Qu'Appelle Health Region did not submit data for the last six months of 2016-17.

Figure 13: Wait times for outpatient mental health and addiction services measured at all levels of urgency – Salaried Psychiatrists

By March 31, 2017, meet benchmarks for contract and salaried psychiatrists 50 per cent of the time.	Percentage meeting benchmarks March 2016	Percentage meeting benchmarks March 2017	Target	Results
Adult Psychiatry*	5 of 7 health regions met the 50 per cent benchmark.	5 of 7 health regions met the 50 per cent benchmark.	50 per cent	Partially achieved
Child and Youth Psychiatry*	0 of 2 health regions met the 50 per cent benchmark.	0 of 2 health regions met the 50 per cent benchmark.	50 per cent	Not achieved

** The Regina Qu'Appelle Health Region did not submit data for the last six months of 2016-17.*

It is important to note that very small numbers affect the overall percentage (e.g., one client not being served within the benchmark triage time results in the target not being met). Wait times to see a psychiatrist will continue to require attention.

Figure 14: Wait times for outpatient mental health and addiction services measured at all levels of urgency – Salaried Psychiatrists

Initiative	Description	Aligns with these Mental Health and Addictions Action Plan Recommendations
Outpatient Mental Health and Addictions Wait Time Reduction: Work to reduce wait times for contract and salaried psychiatry and outpatient mental health and addictions services by meeting benchmarks to improve access.	In 2016-17, the Ministry of Health worked with health regions to make systematic improvements to improve service delivery and reduce wait times. Improvement targets were set at 100 per cent of triage benchmarks being met in outpatient mental health and addiction services, and 50 per cent in contract and salaried psychiatry. In 2016-17, 100 percent of adults with very severe mental health problems were seen within 24 hours; 100 percent of those with severe problems within five working days; 99 percent of those with moderate problems within 20 working days; and 99 percent with mild problems within 30 working days. One hundred per cent of children and youth with very severe mental health problems were seen within 24 hours; 100 per cent of those with severe problems within five working days; 94 per cent of those with moderate problems within 20 working days; and 97 per cent with mild problems within 30 working days. In 2016-17, 100 per cent of adults who presented for outpatient addiction services with very severe problems were seen within 24 hours; 100 per cent with severe problems within five working days; 99 per cent of those with moderate problems within 20 working days; and 99 per cent with mild problems within 30 working days. One hundred per cent of youth who presented for outpatient addiction services with severe problems were seen within five working days; 97 per cent of those with moderate problems within 20 working days; and 100 per cent with mild problems within 30 working days.	Recommendation 2 – *Decrease wait times for mental health and addictions treatments, services, and supports to meet or exceed public expectations, with early focus on counseling and psychiatry supports for children and youth.*
Mental Health First Aid: This course aims to provide a better understanding of mental health and addictions issues, to reduce stigma and to increase awareness. It focuses on the signs and symptoms of addictions and several types of the more common mental health conditions.	In 2016-17, a total of 627 individuals received Mental Health First Aid training by provincially trained facilitators located in regional health authorities across the province. Since January 2015, a total of 1,405 individuals have received training in Saskatchewan. The aim of these courses is to provide a better understanding of mental health and addictions issues to reduce stigma and increase awareness.	Recommendation 11.1 – *Front-line providers across sectors with targeted and relevant education about mental health and addictions issues, including how other service providers work and how to connect clients to services through referral networks.* Recommendation 14.2 – *Develop a public education and awareness program that helps people readily identify mental health and addictions issues and makes it socially acceptable to seek help.*

Initiative	Description	Aligns with these Mental Health and Addictions Action Plan Recommendations
Suicide Prevention: The Ministry of Health continues to work closely with health regions to measure the implementation of the suicide prevention protocols within mental health and addiction services.	In 2016-17, the Ministry of Health began tracking health regions utilization of the suicide prevention protocols. Appropriate utilization includes documentation of an action plan, a safety plan and a follow-up plan. Chart audits submitted by health regions demonstrated that 89 per cent of clients had an action plan on file, 98 per cent had a safety plan and 97 percent had a follow-up plan in place. Funding was provided to Keewatin Yatthé and Mamawetan Churchill River Health Regions to implement evidence-informed suicide prevention activities, for example, knowledge mobilization events, supporting innovative community initiatives and aligning with Embracing Life Committee recommendations.	Recommendation 8.6 – *Enhance the efforts for assessing suicide risk with emphasis on populations most at risk, such as seniors and youth.*
Take Home Naloxone Kits: The Take Home Naloxone Program was launched in response to increased concerns over opioid overdoses and deaths, including fentanyl-related incidents in Saskatchewan.	In 2016-17, the provincial budget included $50,000 for the Take Home Naloxone Kit Program. These funds were used to secure supplies to produce a standard kit for the publicly funded program. Kits were provided and are now available in Saskatoon, Regina Qu'Appelle, Prairie North, Sunrise and Prince Albert Parkland Health Regions.	Recommendation 8.1 – *Promote and enable community health initiatives with focus on higher needs populations.*
Saskatchewan Hospital North Battleford: Rebuilding of the psychiatric rehabilitation hospital, and increasing the number of beds from 156 to 188. This also includes 96 secure beds for male and female offenders living with mental health issues.	The new 284 bed provincial psychiatric facility, will replace the existing 156 bed facility, and will include 188 psychiatric rehabilitation beds, and a secure 96 bed unit for male and female offenders living with mental health issues. Ground breaking occurred on September 21, 2015, with construction now underway. This project is on track to be complete by summer 2018.	Recommendation 11.3 – *Use a cross-sector approach to better identify and address the needs of individuals and families who have significant mental health and/or addictions issues that may require more than a single type of service to provide early intervention, improve stability, and decrease the risk of adverse events.*
Seniors Mental Health: Health regions are continuing to improve the quality of care for residents living in long-term care facilities and who are experiencing mental health issues.	Improvements to seniors' mental health included training within long-term care and the opening of dedicated dementia and behavioural assessment units in Regina Qu'Appelle and Saskatoon Health Regions.	Recommendation 6.1 – *Promote care cultures that improve mental health in long-term care facilities.* Recommendation 6.2 – *Provide formal training for staff in long-term care and home care in mental health and addictions issues most experienced by seniors and enhance resourcing to better respond to identified needs.*

Initiative	Description	Aligns with these Mental Health and Addictions Action Plan Recommendations
Leveraging Immediate Non-Urgent Knowledge (LINK): Piloting of a provincial telephone consultation service to give primary care providers and their patients rapid access to specialists for non-urgent health concerns.	The LINK program is providing family physicians from across the province with an instant connection to consult with a specialist regarding patient issues that are non-emergent yet still important. Adult psychiatry was the first specialty to be offered by LINK. Through LINK, a specialist's expertise can be accessed within the convenience of a primary care visit. The over-the-phone consultation is also an opportunity to help patients get answers to their health concerns sooner.	Recommendation 2.3 – *Facilitate improved access in northern, rural and remote communities through the use of technology, mobile services or other innovations.* Recommendation 3.1 – *Support the work of primary health care providers through team approaches that include ready access to mental health and addictions counselors and consultant psychiatry.*
Internet-based Cognitive Behavioural Therapy (I-CBT): Support the provincial delivery of I-CBT for adults experiencing anxiety and/or depression.	In 2016-17, the Ministry of Health invested $356,000 to support the University of Regina's groundbreaking I-CBT program which provides online clinical treatment for adults suffering from anxiety and depression. The innovative program directly supports the Mental Health and Addictions Action Plan recommendation to provide online clinical treatments for anxiety and depression to increase accessibility to treatment. The program's online capability allows clients from across the province to get the help they need in a timely manner without having to commute for in-office treatment supports.	Recommendation 2.2 – *Provide online clinical treatments for depression and anxiety to increase accessibility to treatment.* Recommendation 2.3 – *Facilitate improved access in northern, rural and remote communities through the use of technology, mobile services or other innovations*
Maternal Mental Health: Fully implement the Maternal Mental Wellness program at HealthLine 811.	The Maternal Wellness Program, a support service for mothers at risk of developing postpartum depression or anxiety was expanded province-wide.	Recommendation 8.2 – *Strengthen access to maternal mental health supports.*
Mental Health Stigma Reduction and Increased Awareness	The Schizophrenia Society of Saskatchewan received funding in 2016-17 to address stigma by expanding the delivery of their Partnership Program which is a public awareness program designed to inform people about schizophrenia and related psychoses, reduce stigma and misconceptions, put a positive face to recovery and dispel myths and fears. It also informs the public how to seek services. The Kids Help Phone also received funding in 2016-17 for its *In the Classroom* program to enhance awareness about mental health, mental well-being. The program provides resources as well as normalizes and de-mystifies the help-seeking process for children and youth. This will help reach children and youth, who in turn, can feel comfortable and confident to seek services whenever they need them.	Recommendation 14.1 – *Expand the delivery of best practice programs shown to reduce stigma.* Recommendation 9.1 – *Increase awareness of mental health and addictions issues in children and youth through schools, including development of skills for lifelong emotional and social health.*

Government Goals

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Primary Health Care

Primary health care is the everyday care we need to protect, maintain or restore our health. For most people, it's the first point of contact with the health care system and the most frequently used health service.

Examples of primary health care include:

- Visiting a family physician or nurse practitioner about the flu, allergies or chronic conditions such as diabetes and arthritis;
- Getting advice from a pharmacist about prescription drugs or aids for quitting smoking;
- Getting support, advice or an appropriate referral to address mental health or substance use issues;
- Getting advice from a dietitian about nutrition; or
- Seeing a physical therapist about exercise programs.

In Saskatchewan, primary health care is delivered by teams of health professionals and independent providers. Advancements in this area have been supported by the vision of the provincial primary health care framework released in 2012. Specific actions include increasing access to services, enhancing the patient experience through team-based programming, quality improvement efforts and supporting the Saskatchewan population in achieving better health.

Chronic Conditions

There are significant numbers of Saskatchewan residents living with chronic health conditions. The burden of chronic disease among Aboriginal peoples and older adults is particularly notable. Saskatchewan has one of the highest rates of hospitalizations for chronic disease in Canada (*Source: Canadian Institute of Health Information – Your Health System*). If current trends continue unmitigated, chronic disease will lead to substantial increases in overall health spending as well as negative impacts on: patient finances and quality of life as well as the economy as a whole.

To better prevent chronic disease and support patients with chronic conditions, work continues to improve access to primary health care and provide chronic disease care consistent with best practice guidelines. The goal is to improve the patient experience, support better health care outcomes for people living with chronic conditions, and reduce both visits to emergency departments and hospitalizations for chronic diseases.

Work to address emergency department visits and hospitalizations related to chronic disease has focused on six chronic conditions common in Saskatchewan: chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), heart failure (HF), asthma, diabetes, and mood disorders (e.g. depression and anxiety).

For more information on primary health care in Saskatchewan, visit www.saskatchewan.ca.

By March 2017, people living with chronic conditions will experience better health as indicated by a 10 per cent decrease in hospital utilization related to six common chronic conditions (Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Heart Failure, Depression, and Asthma).

At the end of March 2016, total hospitalizations (for all conditions combined) had increased 3.94 per cent from baseline; this rate was not sufficient to achieve the 10 per cent reduction in hospitalizations target by the end of 2016-17 year. The trend over a number of years has indicated a decline in hospitalization rates for these 6 conditions combined. This is the first and only time the rate of hospitalizations (for all conditions combined) has been higher than baseline.

The data also showed that:

- Coronary Artery Disease, Diabetes and Asthma have experienced the best results, displaying the most consistent and largest decreases.
- Chronic Obstructive Pulmonary Disease, Chronic Heart Failure and Mood Disorders have experienced the worst results, displaying the least consistent and smallest decreases. It is worth noting that COPD is the worst performing condition and many of our efforts are focused on this disease specifically.

Data for this measure is derived from administrative databases for hospital admissions and emergency department visits. Due to delays in submission of data to both databases – approximately one year - more recent accurate data is not available. The impact of many of our current and future actions is not being reflected in the available results.

Many factors can affect hospital utilization for chronic conditions. We will continue to strengthen our 2016-17 key efforts and add the following in 2017-18:

- Support accountable community-based care planning with a focus on better connecting primary health care providers and facilitating discharges from hospital to the community to provide patients with greater quality and continuity of care in the community and less reliance on hospital-based care;

- Implement recommendations from a Connecting to Care Pilot evaluation report related to enhancing care for complex needs patients;
- Support implementation of initiatives that enhance mental health promotion, tobacco reduction and food security; and
- Develop a toolkit to enhance provider awareness of mental health self-management tools and enhance provider awareness of the University of Regina Internet-based Cognitive Therapy programming (e.g. Internet-based Cognitive Behavioural Therapy).

Key Actions and Results

In support of achieving the 2017 target, the provincial health system is focused on increasing access to enhanced team-based Primary Health Care, greater continuity of care and enhanced best practice care to support reductions in chronic disease hospital utilization and waits in the Emergency Department.

Chronic Disease Care

Chronic disease care was enhanced through the increased adoption and optimized use of Chronic Disease Management-Quality Improvement Program (CDM-QIP) flow sheets to support lower hospitalization rates.

These flow sheets were designed by an expert working group of Saskatchewan clinicians based on clinical practice guidelines and best practices in chronic disease management.

Under CDM-QIP, best practice guidelines and indicators have been identified, and standardized, evidence-based flow sheets (paper and electronic medical record (EMR) versions) have been implemented for all four conditions. These flow sheets assist health care providers to provide optimal care for their patients living with chronic conditions.

In 2016-17 the working group:

- Optimized flow sheets to automate the entry of reported information between different conditions;
- Incorporated the CDM-QIP program into eHealth's maturity model to support optimized use of electronic medical records (EMRs);
- Engaged primary health care providers at events (conferences, regional meetings);
- Provided in-office support via the PHC and Saskatchewan Medical Association EMR teams; and
- Hosted peer-to-peer support events to increase provider interest in the program.

Figure 15: Interim measures and targets developed by the CDM-QIP Steering Committee to track in-year (i.e. 2016-17) progress adopting CDM-QIP tools:

	March 2016	March 2017	Target	Results
Number of providers using the flow sheets	658 Physicians and Nurse Practitioners	799 Physicians and Nurse Practitioners	By March 31, 2017 there are at least 765 providers (Physicians, Nurse Practitioners) submitting CDM visits to the repository	Achieved. Year-end adoption target was exceeded.
Per cent/number of patients for whom data is being submitted though the CDM-QIP repository	21.8 per cent (38,280 discrete patients) The following is a breakdown by condition: Diabetes: 27,025 Coronary Artery Disease: 5,402 Chronic Obstructive Pulmonary Disease: 471 Heart Failure: 46 Multiple Conditions: 5,336	27.7 per cent (49,283 discrete patients) The following is a breakdown by condition: Diabetes: 32,791 Coronary Artery Disease: 6,226 Chronic Obstructive Pulmonary Disease: 1,822 Heart Failure:251 Multiple Conditions: 8,193	By March 31, 2017 45 per cent of patients (80,200 individuals) with one or more of four common chronic conditions (Diabetes, COPD, CAD, Heart Failure) are receiving best practice care as evidence by completion of provincial templates available through approved Electronic Medical Records and the Electronic health Record viewer.	49,283 discrete patients. Partially achieved. While the number of patients increased by 11,003, this increase was insufficient to meet the year-end target.

Figure 15 (on page 22) illustrates two interim measures and targets developed by the CDM-QIP Steering Committee to track in-year (i.e. 2016-17) progress in adoption of the CDM-QIP tools. The target for the percentage of patients living with chronic disease for which data is being submitted through the CDM-QIP repository was not achieved in 2015-16 and this issue has continued into the 2016-17 fiscal year. The low number of patients for whom data is being submitted does not correlate well with the increased number of providers enrolled in CDM-QIP. Proposed corrective actions to achieve this goal include:

- Further data analysis and consultation with providers to better understand program needs and gaps that may result in lower patient enrollment.
- Revise the program metrics: active providers in a 12 month period instead of enrolled providers, in order to more accurately reflect current users of the program.
- Highlight the CDM-QIP through media and communications activities so providers are more informed about the program.
- Organize peer-to-peer events for providers to increase their engagement in the program.

Chronic Obstructive Pulmonary Disease Pathway

The following actions have occurred within the Regina Qu'Appelle Health Region since the fall of 2016:

- Registered nurses and respiratory therapists have been integrated into primary health care teams across the region. These positions will ensure that patients with chronic obstructive pulmonary disease are identified and supported;
- Group COPD education (supporting self-management) and exercise sessions are located throughout the region;
- A registered nurse focused on supporting COPD patients in the hospital through education and when transitioning back into the community;
- Intake and referral processes for pulmonary testing were reviewed and improved in collaboration with physicians; and
- An evaluation plan for the program is currently being designed.

Chronic Obstructive Pulmonary Disease HealthLine 811 Outbound Call Pilot Program

- The Chronic Obstructive Pulmonary Disease Outbound Call Program Pilot is a partnership between HealthLine 811, Kelsey Trail Health Region and the Ministry of Health. It consists of a project team and a clinical team working together, in consultation with patients and medical experts.
- The goal of the program is to prevent or reduce complications related to COPD by providing assessment, monitoring, education and service information for clients living with the disease. These efforts support patient self-management.
- Due to the introduction of a new *Decision Support System* at HealthLine 811 in 2016-17, implementation of this program was delayed and is now slated for 2017-18. The program will be delivered via telephone in partnership with the patient's Primary Health Care team. It is expected this program will:
  - Help ensure patients have better transitions between the hospital and community-based care;
  - Reduce unnecessary hospital admissions and emergency department usage;
  - Ensure patients are comfortable managing their disease at home; and,
  - Improve the quality of life for individuals with chronic obstructive pulmonary disease.

***Connecting to Care Evaluation* Report**

The Connecting to Care Evaluation Report will be complete in 2017-18. Work in 2016-17 included:

- Development of an evaluation plan supported by a provincial committee including health regions, Ministry and other stakeholders;
- Collection of health system utilization data, pilot team activity, and patient and provider interview data;
- Recommendations for program enhancement in summer 2017; and,
- Connecting to Care programming continued in Regina and Saskatoon during the evaluation period.

Planning to determine primary health care areas of focus to reduce waits in the Emergency Department

In 2016-17, planning resulted in an *Accountable Care Strategy*. Cross functional planning continues into 2017-18 as the foundational work to reduce Emergency Department waits including enhancements to community-based and primary health care services. The work in 2017-18 will include development of a provincial approach to primary health care redesign (e.g. networks) and health quality transitions from acute to community.

Expand Access to Care Though Remote Presence Technology in the North

Remote Presence Technology (RPT) is an advanced telemedicine technology. It allows an expert health provider (physician, nurse, pharmacist, etc.) to be virtually "present" in the community to perform real-time assessments, diagnostics and patient management from a remote location, through either a mobile robot or a smaller portable hand-held device known as a "doc-in-a-box". RPT can:

- Provide access to primary and specialized medical care to underserviced communities in real time;
- Improve patient access to health services in their own community, resulting in enhanced patient experience and reduced travel/transport costs;

- Reduce disruptions of visiting services to remote communities due to weather; and,
- Reduce health system costs.

- In 2016-17, based on the successful pilot project in Pelican Narrows, the Government budgeted $500,000 annually to expand RPT to other communities in the North (2016 Throne Speech).
- A working group was established to support implementation of RPT in the North and met several times throughout 2016-17.
- Based on population need, community consultation and its digital infrastructure, LaLoche was the first site identified as a priority for expansion of the RPT. Access to pediatric emergency assessment became available via RPT in LaLoche on April 13, 2017. Additional service lines and communities will be implemented in 2017-18.

Mental Health Promotion

The Ministry conducted consultations with the health regions to identify priority areas to support mental health promotion. Building resiliency and positive mental health in children and youth was identified as a key priority. A proposal to support implementation of initiatives that enhance mental health was developed in 2016-17 with implementation planned for 2017-18, pending resource availability.

Mental Health Self-Management Tools

Efforts to increase awareness of mental health self-management tools (e.g. HealthLine 811 mental health service) included consultations with five primary health care sites across the province delivering some mental health programming to determine what mental health supports primary health care practitioners needed.

From that needs assessment, a number of actions were recommended to frame the work to be completed in 2017-18. The most significant two actions are:

- Developing a toolkit of patient self-management tools for primary health care providers; and,
- Enhancing primary health care provider awareness of the University of Regina online therapy services (Internet-based Cognitive Behavioural Therapy).

Performance Measures

By March 31, 2017, there will be a 50 per cent improvement in the number of people who say "I can access my Primary Health Care Team for care on my day of choice either in person, on the phone or via other technology.".

At the end of November 2016 (the last month where complete data is available) 89.5 per cent of people surveyed reported they received an appointment on their day of choice. Since the inception of the survey there has been an improvement in the number of people who say they can get an appointment on their day of choice, but the results have not been sufficient to show a 50 per cent improvement. Due to a change in survey administration and variability in reporting rates over time it is difficult to show an increase in primary health care access through this measure. Given this, beginning in 2016-17, the Ministry worked with health regions to:

- Examine the results to date and determine what future data from the patient experience survey would best guide quality improvements to patient care;
- Develop an enhanced survey tool and administrative process for data collection and reporting; and,
- Defer this measure until an enhanced patient survey is available for roll-out in 2018-19.

Other Primary Health care Actions in 2016-17

Improve Diabetes Care

The Ministry supported specific work on diabetes in 2016-17. This work relates to enabling best practice care, as well as better planning, monitoring and supports for diabetes programming across the province.

An e-scan in 2016-17 demonstrated all regions have access to core diabetes health care services (i.e. Registered Dietitian, Diabetes Nurse Educator, Physician and Nurse Practitioner); specialist services are available only in the larger centres. Further analysis in 2017-18 will focus on the appropriateness of resource allocation across the province.

Provincial programs supporting patient self-management of include LiveWell with Chronic Conditions and HealthLine/ HealthLine Online are available to all Saskatchewan residents, including those living with diabetes.

On-going support for optimal diabetes care and better patient outcomes continues through:

- Adoption through the CDM-QIP of diabetes and diabetes/coronary artery disease optimal care flow sheets (Note: coronary artery disease is a potential complication of diabetes).
- Incremental funding provided in 2014-15 has resulted in increased access to pediatric specialist services and improved wait times. In June 2015 the wait time for children to access the Pediatric Diabetes Program ranged from 18 to 24 months. In 2016-17, the wait time was reduced to less than three months.
- Coverage of annual optometric visits for patients living with diabetes was introduced in 2014-15 and was accessed by 31,129 diabetes patients in 2016-17. Patients are able to access an annual eye exam, as per recognized best practice guidelines, without cost. Access to annual eye exam facilitates early treatment of eye issues (retinopathy) related to diabetes.
- Increased access to dialysis, a potential complication of diabetes, as a result of service expansion in North

Battleford and Prince Albert. The expansions mean that an additional 21 patients are receiving dialysis closer to home (12 in North Battleford and 9 in Prince Albert).

- Components of the Lower Extremity Wound Pathway were introduced in 2015-16 and 2016-17 and full implementation of the Pathway will be completed in 2017-18.

Provincial diabetes education resource materials for clinicians continue to be updated and are expected to be complete in 2017-18. A review of the *LiveWell with Chronic Conditions* self-management program was completed in 2016-17, and a comprehensive business case based on the recommendations will be developed in 2017-18.

HealthLine 811 Maternal Mental Wellness Program

Women across Saskatchewan who struggle with postpartum depression and anxiety, or feelings of loss following a miscarriage, stillbirth or death of a newborn can now receive support from the HealthLine 811's Maternal Wellness Program. Support continues until they can see their primary care provider or a mental health clinician, or until support is no longer needed.

Women are referred to the Maternal Wellness Program by public health nurses, who screen them for depression and anxiety at the postnatal visit, and two and six month Child Health Clinics. Those who are at risk of or experiencing postpartum depression or anxiety, or suffered a miscarriage, stillbirth or death of a newborn are offered a referral. A registered psychiatric nurse or social worker calls the client at their preferred time to provide emotional support, coping strategies and information on resources in the community.

The program began as a pilot project in Cypress and Kelsey Trail health regions in 2013, and has since expanded province-wide. Between March 2016 and March 2017, it served more than 360 clients. The program supports a recommendation in the *Mental Health and Addictions Action Plan* to improve access to maternal mental health services and is integrated with other areas of the health care system. HealthLine has received positive feedback from clients indicating the program has made a difference for them.

Improved Prenatal Record Form

A working group of physician champions and key stakeholders was established in 2016-17 to review and update the *Saskatchewan Prenatal Record Form*. The Prenatal Record Form is used by health care providers to monitor a woman's pregnancy. Revision will help facilitate prenatal assessment and care based on best practice guidelines.

Specific attention will be focused on incorporating a screening tool for depression and/or anxiety into the Prenatal Record Form. The tool will support consistent identification of and timely care for pregnant women with mental health concerns in 2017-18.

Improving Access to Midwifery Services

Midwives participated in the delivery of almost 2,900 babies in Saskatchewan and work continues to improve access to midwifery services in the province. In 2016-17 $2.4 million was invested in midwifery to help increase capacity, a 63 per cent increase from 2007-08 when the province began funding these services. The results of the funding increases and work to improve midwifery services, since 2007-08, are:

- An expansion of the number of midwife positions from eight to fifteen.
- A provision for health providers, other than midwives, to be the second attendants at home births. This helps increase client access to home births and improves work-life balance for midwives who don't need to be on call as often for home births.

Figure 16: Midwifery Services

	March 2016	March 2017
Midwifery assisted births	2,445 births by midwife client	2,891 births by midwife client

Government Goals

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Seniors

By March 31, 2020, seniors can access supports to remain at home, allowing them to progress into other care options as needs change.

Key Actions and Results

Supporting a Greater percentage of Home Care Clients with Heavier Care Needs

A MAPLe score (method of assigning priority levels) is a tool used by health care professionals to prioritize clients' needs and to appropriately allocate home care resources and placement in long-term care facilities. The MAPLe score ranges from one to five. A score of one represents the highest care needs.

The 2016-17 target was to support a higher percentage of home care clients with heavier care needs as demonstrated by the MAPLe score. The province met the target in all health regions except the Athabasca Health Authority (figure 17). This suggests that there are an increased number of clients with higher care needs living in the community as compared to the previous year.

Continuation of Home First Program

Older adults want to remain safely in their homes longer with dignity, independence and the best health possible. The Home First program reflects government's commitment to patient- and family-centred care, and the growth agenda goal of improving the quality of life for all Saskatchewan people. The program:

- Enhances and improves Home Care's response to crisis and intensive short-term service needs;
- Encourages early discharge from acute care to community options;
- Prevents unnecessary visits to emergency departments; and
- Engages additional service providers in the system to support seniors in their homes.

Regina Qu'Appelle, Saskatoon, Prairie North and Prince Albert Parkland Health Regions participated in the Home First pilot programs. They are continuing in 2017-18.

Long-term Care Facility Quality Indicators

Health regions implemented strategies to reduce the use of anti-psychotics, physical restraints and falls in long-term care in order to meet provincial targets and improve care in long-term care. Provincial indicator rates have been decreasing since the monitoring of quality indicators began in 2013-14. (See figure 18)

Strategies include:

A team approach to making changes in the area of antipsychotic medications.

- Nursing staff review newly admitted residents prescribed antipsychotics.
- Nursing staff also review residents who have been on antipsychotics for years. The physician or RN/NP may lower the dose, and then, if appropriate, eliminate it from a resident's medication regime over time.

Care staff undertook considerable work in understanding the implications of daily restraint use and explored other ways of keeping residents safe.

- Examples include using a Velcro® strap a resident could undo easily or a table that was not secured at the back of the chair.

Figure 17: Percentage of clients with a MAPLe score of three to five living in the community supported by home care.

	March 2016	March 2017	Target	Results
By March 31, 2017, the percentage of clients with a MAPLe score of three to five living in the community supported by home care will increase to 80 per cent.	77 per cent of clients with MAPLe scores 3 to 5 living in the community supported by home care.	80 per cent of clients with MAPLe scores 3 to 5 living in the community are supported by home care.	80 per cent	Achieved

- There has been increased awareness and action taken when restraints are first put in place. Care providers would consider whether there is a continued need for the restraint or if it was an exception. For example, was the resident really tired and the restraint was required for their safety for a single day?

There has been significant work done in the area of falls prevention.

- Over the last number of years, there have been a variety of initiatives implemented for the prevention of falls, such as the Saskatchewan Falls Collaborative which was aimed at reducing falls and injuries from falls, as well, some facilities have been reporting a reduction in the number of falls due to Purposeful Rounding (see description below).
- It has been determined the falls quality indicator is closely tied to both the antipsychotic and physical restraints quality indicators. Often when the use of physical restraints and antipsychotics are reduced, care staff will see the rate of falls increase as they are balancing measures. Residents have the right to "live at risk" if they are capable of making that decision; therefore, they may be subject to falling.

Figure 18: By March 31, 2017, 100 per cent of Saskatchewan long-term care facilities meet the provincial benchmark targets for the seven quality indicators.

Indicator	Actual 2015-16	Actual 2016-17	Provincial Target	Reduction
Reduce use of anti-psychotics in long-term care	27.4 per cent (29.0 per cent target)	24.5 per cent	28.0 per cent	Achieved
Reduce use of physical restraints in long-term care	11.3 per cent (10.7 per cent target)	9.6 per cent	10.4 per cent	Achieved
Reduce falls in long-term care	10.2 per cent (10.0 per cent target)	10.2 per cent	9.0 per cent	Partially achieved
Bladder continence worsened	17.7 per cent (17.0 per cent target)	16.0 per cent	18.12 per cent	Partially achieved
Pain Worsened	8.9 per cent (9 per cent target)	8.0 per cent	9.51 per cent	Partially achieved
Newly Occurring Stage 2-4 Pressure Ulcer	1.5 per cent (2.0 per cent target)	2.0 per cent	1.67 per cent	Achieved
Worsened Stage 2-4 Pressure Ulcer	1.7 per cent (2.0 per cent target)	2.0 per cent	1.83 per cent	Achieved

Each year most targets are changed to encourage continued improvement for each quality indicator. This changing value is more challenging for facilities to meet.

Purposeful Rounding

Purposeful Rounding is the practice of regularly checking on residents' needs using the 4Ps – positioning, personal needs, pain and proximity of personal items such as the call light – with the promise to return in a prescribed amount of time. It was implemented in 89 long-term care facilities (67 per cent of facilities) in 2015-16. Feedback has been positive especially in the area of decreasing falls and reducing the use of call bells. Provincially, 138 of 158 facilities implemented Purposeful Rounding in 2016-17.

Figure 19: Long-term care facilities using purposeful rounding

	March 2016	March 2017	Target	Results
By March 31, 2017, 67 per cent of long-term care facilities will have implemented Purposeful Rounding.	58 per cent of long-term care facilities using Purposeful Rounding. Target was 33 per cent.	86 per cent of long-term care facilities using Purposeful Rounding.	67 per cent	Achieved

Long-term care resident and family experience survey

The long-term care resident and family experience survey was finalized and implemented. Health regions worked in collaboration with the Health Quality Council to develop a Long-Term Care Resident and Family Experience Survey that met accreditation standards. All health regions, except the north (Keewatin Yatthé, Mamawetan Churchill River and Athabasca) completed their surveys and a provincial baseline was established. Given the low number of long-term care residents in the north, survey results would not significantly impact the baseline.

The survey will be administered biannually to provide data for comparison.

Figure 20: Long-term care facilities using purposeful rounding

	March 2016	March 2017	Target	Results
By March 31, 2017, a baseline will be established for resident and family experience in long-term care.	N/A	Surveys completed and baseline established	Baseline established	Achieved

Educational Resources in Long-Term Care Facilities

The goal in 2016-17 was for care staff in long-term care facilities to review all modules of the *Program Guidelines for Special-Care Homes DVD* (see figure 21). While this measure came in at 83 per cent (below the goal of 100 per cent) at year-end, it trended in the right direction throughout the year and is planned to be completed in 2017-18.

Figure 21: Percentage of long-term care staff who have reviewed all modules of the Program Guidelines for Special-Care Homes

	March 2016	March 2017	Target	Results
By March 31, 2017, 100 per cent of long-term care staff have reviewed all modules of the Program Guidelines for Special-Care Homes.	N/A	83 per cent of care staff reviewed educational materials on program guidelines for Special-Care Homes.	100 per cent	Partially achieved

Seniors' House Calls

The Seniors' House Calls program focuses on providing seniors with complex health conditions with medical care and support in their homes, allowing them to age safely in their homes for as long as possible. It has been fully implemented in both Regina and Saskatoon, and both are reporting on the following measures:

- Number of visits to clients in their homes;
- Number of clients seen in their homes;
- Number of emergency department visits avoided; and,
- Number of admissions avoided (estimated; only available for Regina Qu'Appelle).

The program is designed to receive referrals from acute care (both the emergency department and acute care units in the hospital) as well as from community care (such as home care and family physicians). Home visits are based on a need for urgent access to care or post-hospital follow-up care. This may be due to mobility challenges, acute illness, or a lack of urgent to semi-urgent access to family doctors. The Seniors' House Calls program combines resources with Community Paramedicine, Home First, and the Geriatric Evaluation Management Services (GEMS; Saskatoon only) to create an interdisciplinary Seniors' House Calls team. Clients of the program receive individualized care plans and a single phone number that connects them with the team. The team's goal is to provide responsive, home-based, primary health care services and to connect clients with longer-term care services such as home care. Clients are able to access the care they need and remain at home, avoiding emergency department visits or readmissions after a hospital stay.

Performance Measures

Figure 22: Decreased number of emergency department visits, hospital admissions and hospital readmissions as a result of the Seniors' House Calls Program

	March 2016	March 2017	Target	Success
Decreased number of Emergency Department visits in client cohort by 50 per cent over baseline (prior year usage).	"Emergency Department visits *avoided*"* was measured as a proxy: Regina: 18 Saskatoon: 72	"Emergency Department visits *avoided*": Regina: 49; Saskatoon: 129 Number of monthly ED visits *avoided* has increased for both Regina (270 per cent) and Saskatoon (180 per cent).	Decrease by 50 per cent over baseline.	Achieved
Decreased rate of hospital admissions in client cohort by 50 per cent over baseline.	"Hospital admissions *avoided*"† was measured as a proxy: Regina: 4; Saskatoon: unavailable	"Hospital admissions *avoided*": Regina: 11; Saskatoon: unavailable	Decrease by 50 per cent over baseline.	Achieved Regina: Hospital admissions avoided have increased by 275 per cent. Saskatoon: unavailable
Decreased rate of hospital readmissions in client cohort by 50 per cent over baseline.	Unavailable. "Readmissions avoided" was not measured as a proxy as this data was not collected by program teams.	Unavailable. "Readmissions avoided" was not measured as a proxy as this data was not collected by program teams.	Decrease by 50 per cent over baseline.	Unavailable.

*An emergency department visit is considered avoided when a condition that would usually lead the client to visit the emergency department is instead treated in the community or prevented altogether.

† Regina uses historical emergency department admissions data for this client cohort to estimate hospital admissions avoided.

Government Goals

Sustaining growth and opportunities for Saskatchewan people	Meeting the challenges of growth	Securing a better quality of life for all Saskatchewan people	Delivering responsive and responsible government

These actions support the Saskatchewan Plan for Growth with Better Teams

Ministry Goal

Build safe, supportive and quality workplaces that support patient- and family-centred care and collaborative practices. Develop a highly skilled, professional and diverse workforce that has a sufficient number and mix of service providers.

Culture of Safety

To achieve a culture of safety in which by March 31, 2020 there will be no harm to patients or staff.

Key Actions and Results

Progress towards achieving 100 per cent on the Safety Alert/Stop the Line Implementation Assessment. By March 31, 2017, all health regions and the Cancer Agency will achieve a 100 per cent score on their Safety Alert/Stop the Line Implementation Assessment.

Safety Alert/Stop the Line (SA/STL) is a process that invites patients and families, and expects staff and physicians, to be safety inspectors, to identify potentially harmful situations as soon as possible, and to 'stop the line' and fix them in the moment, before they can cause harm. Learn more about SA/STL in this video co-produced by the Saskatchewan Health Quality Council and the Saskatoon Health Region in 2016 called *Making Health Care SAFER for Everyone.*

The SA/STL Implementation Assessment is a self-assessment tool developed in collaboration with regional health authorities. The Implementation Assessment contains 17 elements in five categories:

1. Organizational capability to lead safety.
2. Safety is visual to the organization.
3. Safety improvement is continuous in the organization.
4. Safety is an expectation throughout the organization.
5. SA/STL behaviours are staff competencies in the organization.

Each of the 17 elements includes criteria to guide assessment. For example, under organizational capability to lead safety element number three is: leaders know and can lead root cause analyses for safety events, with the accompanying criterion of: Senior leaders have completed Root *Cause Analysis/ Investigations* training (all=3; most=2; some=1; none=0).

Each health region used this tool to assess its own progress in establishing a solid foundation to support a culture of safety for patients and staff. Regions conducted their assessments once each quarter as a way to monitor progress. In their last assessment of the year, five regions (Sun Country, Five Hills, Sunrise, Kelsey Trail, and Prince Albert Parkland) scored above 95 per cent; six regions (Cypress, Regina Qu'Appelle, Saskatoon, Prairie North, Mamawetan Churchill River, and Keewatin Yatthé) scored between 70 per cent and 95 per cent; and two regions (Heartland and Athabasca Health Authority) scored below 70 per cent. The Saskatchewan Cancer Agency did not provide an assessment.

Health regions continue to put these important elements in place, and to ensure that they are spread throughout their organizations.

Progress towards implementation of the Safety Management System.

By March 31, 2017, all health regions and the Saskatchewan Cancer Agency will have implemented the Safety Management System.

The Safety Management System (SMS) is a six-element, focused process that supports safe work practices in which health care providers work together with patients, families and care providers to ensure that we are all accountable for safety, and safety is everyone's responsibility. The six elements are:

1. Leadership and Commitment.
2. Hazard Identification and Control.
3. Training and Communications.
4. Inspections.
5. Investigations.
6. Emergency Response.

These health regions are on target for implementation: Sunrise, Keewatin Yatthé, Mamawetan Churchill River, Heartland, and Prince Albert Parkland. Progress is occurring in most health regions; however, the timelines for implementation are challenging. The remaining seven regions (Sun Country, Five Hills, Cypress, Regina Qu'Appelle, Saskatoon, Kelsey Trail, and Prairie North) continue towards full implementation in 2017-18.

Medication reconciliation at hospital discharge

By March 31, 2017, 95 per cent or more of care transitions where clients are at risk of medication errors will have medication reconciliation performed. Note: This target was changed to 80 per cent or more for 2016-17.

Medication reconciliation (MedRec) is a formal process in which health care providers work together with patients, families, and care providers to ensure that accurate, comprehensive medication information is communicated consistently across transitions of care.

Excluding Regina Qu'Appelle and Saskatoon Health Regions, the provincial average compliance with medication reconciliation at discharge/transfer was 84 per cent in March 2017. Saskatoon scored 36 per cent, and Regina Qu'Appelle two per cent. (In Regina Qu'Appelle Health Region, only All Nations' Healing Hospital has been auditing medication reconciliation at discharge/transfer, and the facility accounts for approximately two per cent of the region's discharges.)

In 2016-17, the provincial Medication Reconciliation at Discharge/Transfer form was revised with input from regional health authorities. This form is being incorporated into the electronic pharmacy system being deployed across the province over the coming year. The new computerized form will make it much easier for larger hospitals to implement medication reconciliation.

Government Goals

Sustaining growth and opportunities for Saskatchewan people	Meeting the challenges of growth	Securing a better quality of life for all Saskatchewan people	Delivering responsive and responsible government

Strategic priority in support of the Saskatchewan Plan for Growth: Better Value

Ministry Goal

Achieve best value for money, improve transparency and accountability, and strategically invest in facilities, equipment and information infrastructure.

Strategy

Bending the Cost Curve: Health costs continue to increase. A focused effort is required to ensure the health system is sustainable into the future. Ongoing, as part of a multi-year budget strategy, the health system will bend the cost curve by achieving a balanced or surplus budget.

Key Actions and Results

- Health regions and organizations undertook 333 continuous improvement activities or events, including shared services initiatives, resulting in projected financial impacts and savings of $11.1 million.
  - Of these improvements, Shared Services Saskatchewan (3sHealth) is reducing the risk of medication errors in health regions and Saskatchewan Cancer Agency facilities by introducing intravenous "smart" pumps.
  - Capital avoidance and annual system savings through ongoing cost of consumables is projected to be $9.9 million.

Performance Measures

2016-17 Regional Health Authorities, Athabasca Health Authority and Saskatchewan Cancer Agency financial status, as measured by surplus/deficit.

- Not all health system organizations are in a balanced or surplus position as of March 31, 2017. Combined, regional health authorities and Saskatchewan Cancer Agency ended the year with a $5.1 million operating deficit. This deficit is a result of service pressures in the regional health authorities.
- See the regional health authorities' financial statements beginning on page 38 for further details and breakdown by organization.

Financial Overview

The Ministry of Health spent or allocated $5.2 billion in expenditures in 2016-17, $13.6 million more than its 2016-17 budget. During 2016-17, the Ministry received $16 million through special warrant funding for increased utilization costs and operating pressures in the Regional Health Authorities.

In 2016-17, the Ministry received $13.3 million of revenue, $3.9 million more than its 2016-17 budget. The additional revenue is primarily due to increased expense recoveries.

In 2016-17, the Ministry employed 508.1 full time equivalent staff (FTEs), 11.2 FTEs greater than its 496.9 FTE budget. The variance was primarily the result of employing more students.

Ministry of Health Comparison of Actual Expense to Estimates

	2015-16 Actuals $000s	2016-17 Estimates $000s	2016-17 Actuals $000s	2016-17 Variance $000s	Notes
Central Management and Services					
Ministers' Salary (Statutory)	96	98	98	-	
Executive Management	2,238	2,349	2,289	(60)	
Central Services	4,724	6,167	4,576	(1,591)	
Accommodation Services	2,742	2,707	2,686	(21)	
	9,800	**11,321**	**9,649**	**(1,672)**	
Regional Health Services					
Athabasca Health Authority Inc.	7,034	7,034	7,034	-	
Cypress Regional Health Authority	121,261	126,496	125,130	(1,366)	
Five Hills Regional Health Authority	143,897	147,941	146,076	(1,865)	
Heartland Regional Health Authority	91,590	94,647	93,396	(1,251)	
Keewatin Yatthe Regional Health Authority	26,911	27,365	27,006	(359)	
Kelsey Trail Regional Health Authority	112,180	114,704	113,377	(1,327)	
Mamawetan Churchill River Regional Health Authority	28,684	29,459	28,747	(712)	
Prairie North Regional Health Authority	211,373	220,256	217,606	(2,650)	
Prince Albert Parkland Regional Health Authority	210,073	218,558	216,073	(2,485)	
Regina Qu'Appelle Regional Health Authority	904,043	936,165	926,806	(9,359)	
Saskatoon Regional Health Authority	1,030,113	1,080,528	1,071,456	(9,072)	
Sun Country Regional Health Authority	137,193	141,147	139,653	(1,494)	
Sunrise Regional Health Authority	193,894	199,087	196,971	(2,116)	
Regional Targeted Programs and Services	89,477	40,217	93,105	52,888	(1)
Saskatchewan Cancer Agency	154,695	167,080	163,931	(3,149)	
Facilities - Capital	95,563	56,132	47,638	(8,494)	(2)
Equipment - Capital	8,040	15,300	16,950	1,650	
Regional Programs Support	29,614	26,762	27,981	1,219	
Subtotal	**3,595,635**	**3,648,878**	**3,658,936**	**10,058**	
Provincial Health Services					
Canadian Blood Services	43,329	41,350	48,384	7,034	(3)
Provincial Targeted Programs and Services	53,189	56,809	51,090	(5,719)	(4)
Provincial Laboratory	27,311	27,699	28,091	392	
Health Quality Council	4,763	4,968	-	(4,968)	
Immunizations	13,928	16,092	14,490	(1,602)	
eHealth Saskatchewan	61,937	64,451	66,798	2,347	
Subtotal	**204,457**	**211,369**	**208,853**	**(2,516)**	
Medical Services & Medical Education Programs					
Medical Services - Fee-for-Service	543,877	534,686	557,334	22,648	
Medical Services - Non-Fee-for-Service	151,019	159,651	151,334	(8,317)	(5)
Medical Education System	59,888	68,528	66,378	(2,150)	
Optometric Services	11,699	11,323	12,385	1,062	
Dental Services	2,112	2,183	1,653	(530)	
Out-of-Province	136,358	127,412	129,410	1,998	
Program Support	3,854	4,514	4,071	(443)	
Subtotal	**908,807**	**908,297**	**922,566**	**14,269**	

	2015-16 Actuals $000s	2016-17 Estimates $000s	2016-17 Actuals $000s	2016-17 Variance $000s	Notes
Drug Plan & Extended Benefits					
Saskatchewan Prescription Drug Plan	301,929	311,800	300,856	(10,944)	
Saskatchewan Aids to Independent Living	42,436	42,084	43,505	1,421	
Supplementary Health Program	23,132	23,537	24,556	1,019	
Family Health Benefits	4,093	4,546	4,338	(208)	
Multi-Provincial Human Immunodeficiency Virus Assistance	225	263	230	(33)	
Program Support	4,530	4,610	4,594	(16)	
Subtotal	**376,345**	**386,840**	**378,079**	**(8,761)**	
Early Childhood Development	**11,032**	-	-	-	
Provincial Infrastructure Projects	**15,685**	**184,225**	**184,225**	-	
APPROPRIATION	**5,121,761**	**5,350,930**	**5,362,307**	**11,377**	
Capital Asset Acquisitions	(15,778)	(184,648)	(184,225)	423	
Non-Appropriated Expense Adjustment	3,562	842	2,607	1,765	
TOTAL EXPENSE	**5,109,545**	**5,167,124**	**5,180,689**	**13,565**	
Special Warrant	-	16,000	-	(16,000)	(6)
REVISED TOTAL EXPENSE	**5,109,545**	**5,183,124**	**5,180,689**	**(2,435)**	
FTE STAFF COMPLEMENT	**499.4**	**496.9**	**508.1**	**11.2**	

Approximately 90 percent of the expenditures were provided to third parties for health care services, health system research, information technology support, and coordination of services such as the blood system. The majority of the remaining funding was primarily paid to individuals through the Saskatchewan Prescription Drug Plan and extended benefit programs.

Explanations for Major Variances

Explanations are provided for all variances that are both greater than 5 percent of the Ministry's 2016-17 program budget and greater than 0.1 percent of the Ministry's total expense.

1. Primarily due to increased operating pressures in the Regional Health Authorities.
2. Decrease due to less than anticipated capital transfers to Regional Health Authorities.
3. Program utilization above budgeted levels.
4. Net program under-expenditures and utilization below budgeted levels.
5. Primarily due to one-time savings in physician services.
6. Special Warrant funding received for increased utilization costs and operating pressures in the Regional Health Authorities.

Ministry of Health Comparison of Actual Revenue to Budgeted Revenue

	2016-17 Estimates $000s	2016-17 Actuals $000s	Variance $000s	Note
Other Own-source Revenue				
Investment Income	115	103	(12)	
Other fees and charges	2,396	2,456	60	
Miscellaneous	1,463	5,331	3,868	(1)
Total	3,974	7,890	3,916	
Transfers from the Federal Government	5,451	5,426	(25)	
TOTAL REVENUE	**9,425**	**13,316**	**3,891**	

The Ministry collects transfer revenue from the federal government for various health-related initiatives and services. The major federal transfers include amounts for some air ambulance services, implementation of the *Youth Criminal Justice Act*, employment assistance for persons with disabilities, and programs to assist with drug treatments for youth. The Ministry also collects revenue through fees for services such as personal care home licenses and water testing fees. All revenue is deposited to the credit of the General Revenue Fund.

Explanations for Major Variances

Variance explanations are provided for all variances greater than $1,000,000.

1. Primarily as a result of higher than anticipated expense recoveries.

Regional Health Authorities

Operating Fund Financial Statements[1] (In 000s Dollars)

STATEMENT OF OPERATIONS AND CHANGE IN FUND BALANCES	Cypress	Five Hills	Heartland	Keewatin Yatthé	Kelsey Trail	Mamawetan Churchill River
Operating Revenues:						
Ministry of Health - General Revenue	132,328	149,983	93,873	27,643	113,927	29,589
Other Provincial Revenue	299	2,527	255	471	1,197	322
Federal Government Revenue	68	582	-	85	1	29
Funding from other Provinces	-	-	-	-	-	-
Patient & Client Fees	8,773	3,764	9,825	1,263	8,756	403
Out of Province Revenue (Reciprocal)	1,451	1,149	669	-	629	47
Out of Country Revenue	83	78	29	-	36	6
Donations	53	21	176	-	1	3
Ancillary Operations - income	-	565	174	-	857	127
Investment Income	238	246	188	54	129	48
Recoveries	3,243	2,189	2,336	61	1,963	789
Research Grants	-	-	-	-	-	-
Other Revenue	483	21	248	389	2,460	130
Total Operating Revenue	**147,019**	**161,125**	**107,773**	**29,966**	**129,955**	**31,494**
Operating Expenses:						
Inpatient & resident services						
Nursing Administration	3,574	1,826	4,334	308	3,607	-
Acute	16,830	22,948	4,693	5,404	15,209	3,707
Supportive	20,963	37,626	6,703	2,256	19,565	1,183
Integrated	14,651	-	28,046	-	6,037	-
Rehabilitation	-	-	-	-	-	-
Mental health & addictions	1,607	2,183	-	-	-	-
Total inpatient & resident services	**57,626**	**64,583**	**43,776**	**7,968**	**44,417**	**4,890**
Physician compensation	**15,441**	**16,973**	**3,080**	**35**	**10,126**	**611**
Ambulatory care services	**3,266**	**7,594**	**188**	**-**	**3,143**	**-**
Diagnostic & therapeutic services	**11,959**	**13,582**	**10,017**	**2,404**	**12,217**	**2,234**
Community health services						
Primary health care	2,376	2,365	1,268	2,757	2,753	3,084
Home care	6,853	9,997	7,329	1,443	8,746	2,226
Mental health & addictions	2,852	7,291	3,412	2,652	2,868	3,274
Population health	2,779	4,238	3,447	3,079	5,017	4,601
Emergency response services	4,609	3,315	6,155	2,712	4,777	1,996
Other community services	1,345	909	379	-	637	647
Total community health services	**20,814**	**28,115**	**21,990**	**12,643**	**24,798**	**15,828**
Support services						
Program support	6,555	7,753	5,691	3,472	7,796	3,733
Operational support	24,694	18,441	20,898	4,116	24,531	3,809
Other support	888	246	602	87	410	(13)
Employee future benefits	56	21	70	16	42	26
Total support services	**32,193**	**26,461**	**27,261**	**7,691**	**32,779**	**7,555**
Ancillary	**41**	**171**	**122**	**-**	**-**	**17**
Total Operating Expenses	**141,340**	**157,480**	**106,434**	**30,741**	**127,480**	**31,135**
Operating Fund Excess/(Deficiency)	**5,679**	**3,645**	**1,339**	**(775)**	**2,475**	**359**
Interfund Transfers	(6,611)	(3,645)	(1,339)	-	(3,340)	(176)
Increase (decrease) in fund balances	**(932)**	**-**	**-**	**(775)**	**(865)**	**183**
Operating Fund Balance - Beginning of the year	8,229	1,428	(1,338)	-	(5,386)	484
Operating Fund Balance - End of Year	**7,297**	**1,428**	**(1,338)**	**(775)**	**(6,251)**	**667**
STATEMENT OF FINANCIAL POSITION						
Operating Assets:						
Cash and Short-term Investments	22,566	22,288	10,456	2,486	7,543	4,654
Accounts Receivable:						
Ministry of Health	382	399	230	-	154	13
Other	1,147	1,833	919	791	1,456	699
Inventory	702	799	1,474	308	616	168
Prepaid Expenses	162	1,072	611	216	853	99
Due from (to) Restricted Fund	-	-	-	-	-	-
Investments	886	86	2,203	10	1,286	-
Other Assets	-	-	-	-	35	-
Total Operating Assets	**25,845**	**26,477**	**15,893**	**3,811**	**11,943**	**5,633**
Liabilities and Operating Fund Balance:						
Accounts Payable	3,443	9,051	1,229	1,056	2,684	1,133
Bank Indebtedness	-	-	-	-	-	-
Accrued Liabilities:						
Accrued Salaries	3,039	3,714	3,551	816	3,281	769
Vacation Payable	8,380	6,639	6,915	1,639	7,501	1,506
Other	-	-	-	-	-	-
Employee Future Benefits	3,290	3,043	3,114	829	4,141	859
Deferred Revenue	398	2,602	2,422	247	588	698
Ministry of Health	86	2,058	314	33	520	99
Non-Ministry of Health	312	544	2,108	213	68	599
Due to (from) other funds	-	-	-	-	-	-
Total Operating Liabilities	**18,550**	**25,049**	**17,231**	**4,586**	**18,195**	**4,965**
Externally Restricted	-	-	-	-	-	-
Internally Restricted	-	-	-	-	-	-
Unrestricted	7,297	1,428	(1,338)	(775)	(6,251)	669
Operating Fund Balance	**7,297**	**1,428**	**(1,338)**	**(775)**	**(6,251)**	**669**
Total Liabilities and Fund Balance	**25,845**	**26,477**	**15,893**	**3,811**	**11,943**	**5,633**

STATEMENT OF OPERATIONS AND CHANGE IN FUND BALANCES	Prairie North	Prince Albert Parkland	Regina Qu'Appelle	Saskatoon	Sun Country	Sunrise	Grand Total
Operating Revenues:							
Ministry of Health - General Revenue	225,362	221,310	956,400	1,161,278	141,168	200,686	3,453,547
Other Provincial Revenue	4,003	3,853	20,036	22,014	400	2,001	57,378
Federal Government Revenue	107	702	7,480	1,304	-	2	10,360
Funding from other Provinces	41,645	-	-	-	-	-	41,645
Patient & Client Fees	2,740	7,167	27,509	15,073	11,211	13,581	110,065
Out of Province Revenue (Reciprocal)	126	929	10,677	9,231	454	3,526	28,888
Out of Country Revenue	230	164	2,022	2,880	39	164	5,731
Donations	209	97	466	-	163	163	1,352
Ancillary Operations - income	2,046	1,000	7,067	19,009	-	1,273	32,118
Investment Income	3,531	106	37	-	155	82	4,814
Recoveries	-	4,296	17,797	34,518	4,185	5,779	77,156
Research Grants	-	-	63	-	-	-	63
Other Revenue	715	901	7,001	3,218	52	95	15,713
Total Operating Revenue	**293,009**	**240,526**	**1,056,555**	**1,268,525**	**157,827**	**227,354**	**3,851,128**
Operating Expenses:							
Inpatient & resident services							
Nursing Administration	8,166	4,829	3,346	11,771	568	4,832	47,161
Acute	42,594	44,673	217,244	284,250	5,722	33,968	697,242
Supportive	41,077	40,675	125,438	152,477	25,567	47,201	520,731
Integrated	-	-	21,715	-	38,603	-	109,052
Rehabilitation	-	-	6,507	5,491	-	-	11,998
Mental health & addictions	14,505	5,971	13,794	12,438	1,821	2,592	54,911
Total inpatient & resident services	**106,343**	**96,148**	**388,044**	**466,427**	**72,281**	**88,593**	**1,441,096**
Physician compensation	**21,405**	**23,108**	**96,637**	**133,996**	**7,417**	**13,831**	**342,660**
Ambulatory care services	**12,879**	**12,744**	**92,109**	**101,242**	**2,410**	**6,912**	**242,487**
Diagnostic & therapeutic services	**30,558**	**22,008**	**130,181**	**165,963**	**11,358**	**21,066**	**433,547**
Community health services							
Primary health care	6,497	3,838	52,282	4,497	2,301	3,565	87,583
Home care	12,166	13,791	16,574	50,174	10,666	13,055	153,020
Mental health & addictions	12,065	12,242	27,516	38,743	4,859	5,178	122,952
Population health	8,842	7,782	15,544	29,866	4,245	7,469	96,909
Emergency response services	7,946	4,660	18,924	21,913	5,833	6,537	89,377
Other community services	1,496	417	4,236	8,328	511	1,307	20,212
Total community health services	**49,012**	**42,730**	**135,076**	**153,521**	**28,415**	**37,111**	**570,053**
Support services							
Program support	20,988	10,723	53,429	67,280	9,699	15,793	212,912
Operational support	45,650	33,449	155,449	156,204	23,205	38,833	549,279
Other support	414	398	5,804	2,999	2,300	969	15,104
Employee future benefits	246	198	583	790	188	88	2,324
Total support services	**67,298**	**44,768**	**215,265**	**227,273**	**35,392**	**55,683**	**779,619**
Ancillary	**920**	**384**	**2,790**	**15,823**	**-**	**1,440**	**21,708**
Total Operating Expenses	**288,415**	**241,890**	**1,060,102**	**1,264,245**	**157,273**	**224,636**	**3,831,170**
Operating Fund Excess/(Deficiency)	**4,594**	**(1,364)**	**(3,547)**	**4,280**	**554**	**2,718**	**19,957**
Interfund Transfers	(4,507)	(946)	(370)	(1,015)	(929)	(1,990)	(24,868)
Increase (decrease) in fund balances	**87**	**(2,310)**	**(3,917)**	**3,265**	**(375)**	**728**	**(4,911)**
Operating Fund Balance - Beginning of the year	(16,353)	(23,142)	(146,569)	(152,587)	(5,819)	(38,504)	(379,557)
Operating Fund Balance - End of Year	**(16,266)**	**(25,452)**	**(150,486)**	**(149,322)**	**(6,194)**	**(37,776)**	**(384,468)**
STATEMENT OF FINANCIAL POSITION							
Operating Assets:							
Cash and Short-term Investments	13,807	6,926	-	7,966	10,539	2,432	111,663
Accounts Receivable:							
Ministry of Health	932	37	2,528	3,063	155	762	8,655
Other	3,956	2,350	14,164	18,109	2,385	1,707	49,516
Inventory	1,910	1,376	4,492	11,589	741	1,159	25,334
Prepaid Expenses	1,660	683	5,089	4,590	456	1,206	16,697
Due from (to) Restricted Fund	-	-	(20,613)	-	-	-	(20,613)
Investments	2,399	-	-	-	18	701	7,589
Other Assets	-	-	-	-	-	-	35
Total Operating Assets	**24,664**	**11,372**	**5,660**	**45,317**	**14,294**	**7,967**	**198,876**
Liabilities and Operating Fund Balance:							
Accounts Payable	9,619	8,829	40,976	65,232	1,515	2,963	147,730
Bank Indebtedness	-	-	1,550	-	-	12,942	14,492
Accrued Liabilities:							
Accrued Salaries	6,402	5,076	22,337	29,818	6,345	6,396	91,544
Vacation Payable	15,840	13,853	55,260	56,491	7,739	14,707	196,470
Other	12	-	-	-	-	1,152	1,164
Employee Future Benefits	7,567	6,130	26,349	28,101	3,823	6,652	93,898
Deferred Revenue	1,510	2,935	9,674	14,997	1,067	934	38,070
Ministry of Health	162	1,702	4,453	6,045	190	108	15,770
Non-Ministry of Health	1,347	1,233	5,221	8,952	877	825	22,299
Due to (from) other funds	-	-	-	-	-	-	-
Total Operating Liabilities	**40,949**	**36,823**	**156,146**	**194,639**	**20,489**	**45,745**	**583,367**
Externally Restricted	-	-	-	-	-	-	-
Internally Restricted	449	-	(764)	-	1	38	(276)
Unrestricted	(16,735)	(25,452)	(149,722)	(149,322)	(6,197)	(37,816)	(384,218)
Operating Fund Balance	**(16,286)**	**(25,452)**	**(150,486)**	**(149,322)**	**(6,196)**	**(37,778)**	**(384,494)**
Total Liabilities and Fund Balance	**24,664**	**11,372**	**5,660**	**45,317**	**14,294**	**7,967**	**198,873**

[1] Some items may not balance due to rounding.

Restricted Fund Financial Statements[1,2] (In 000s Dollars)

STATEMENT OF OPERATIONS AND CHANGE IN FUND BALANCES	Cypress	Five Hills	Heartland	Keewatin Yatthé	Kelsey Trail	Mamawetan Churchill River
Restricted Revenues:						
Ministry of Health - General Revenue Fund	6,768	1,001	650	580	2,943	410
Other Government of Saskatchewan	-	36	102	-	234	-
Federal Government revenue	-	-	-	-	-	-
Funding from other Provinces	-	-	-	-	-	-
Donations	1,304	2,406	189	-	1,618	8
Ancillary Operations - income	-	21	-	-	-	-
Investment Income	32	197	100	-	60	9
Recoveries	-	-	-	-	-	91
Other Revenue	2,566	30	-	-	55	7
Total Restricted Revenue	**10,670**	**3,691**	**1,041**	**580**	**4,910**	**525**
Restricted Expenses:						
Inpatient & resident services						
Nursing Administration	-	31	-	-	-	706
Acute	2,043	1,057	139	66	1,655	-
Supportive	7,056	267	58	31	2,068	383
Integrated	1,735	-	4,877	-	1,040	-
Rehabilitation	-	-	-	-	-	-
Mental health & addictions	-	27	-	-	-	-
Total inpatient & resident services	**10,834**	**1,382**	**5,074**	**97**	**4,763**	**1,089**
Physician compensation	**-**	**-**	**-**	**-**	**-**	**-**
Ambulatory care services	**370**	**258**	**-**	**-**	**-**	**-**
Diagnostic & therapeutic services	**1,513**	**1,766**	**-**	**63**	**33**	**4**
Community health services						
Primary health care	-	11	1	9	-	1
Home care	-	384	12	-	-	-
Mental health & addictions	-	12	-	1	-	-
Population health	-	2	4	28	-	-
Emergency response services	553	1	352	69	69	-
Other community services	-	7	-	-	60	-
Total community health services	**553**	**417**	**369**	**107**	**129**	**1**
Support services						
Program support	36	762	20	100	-	10
Operational support	-	622	-	849	81	-
Other support	-	4,047	-	-	-	-
Total support services	**36**	**5,431**	**20**	**949**	**81**	**10**
Ancillary	**-**	**-**	**-**	**-**	**-**	**3**
Total Restricted Expenses	**13,306**	**9,254**	**5,463**	**1,216**	**5,006**	**1,107**
Restricted Fund Excess/(Deficiency)	**(2,636)**	**(5,563)**	**(4,422)**	**(636)**	**(96)**	**(582)**
Interfund Transfers	6,611	3,645	1,339	-	3,340	176
Other Transfers	-	-	-	-	-	-
Increase (decrease) in fund balances	**3,975**	**(1,918)**	**(3,083)**	**(636)**	**3,244**	**(406)**
Restricted Fund Balance - Beginning of the year	238,048	136,784	98,605	22,308	66,952	9,749
Restricted Fund Balance - End of Year	**242,023**	**134,866**	**95,522**	**21,672**	**70,196**	**9,343**
STATEMENT OF FINANCIAL POSITION						
Restricted Assets:						
Cash and Short-term Investments	2,533	22,423	5,155	2,322	7,662	1,080
Accounts Receivable:						
Ministry of Health	107,265	-	278	-	589	-
Other	16,054	12	168	-	616	340
Prepaid Expenses	-	-	-	-	-	-
Due From (Community Trust Fund)	-	-	-	-	-	-
Investments	-	229	1,298	1	-	-
Capital Assets	238,746	113,199	92,235	19,350	69,275	8,098
Other Assets	-	-	-	-	156	-
Total Restricted Assets	**364,598**	**135,863**	**99,134**	**21,673**	**78,298**	**9,518**
Liabilities and Restricted Fund Balance:						
Accounts Payable	-	6	21	-	921	4
Accrued Liabilities	121,743	-	-	-	-	-
Deferred Revenue (Non-Ministry of Health)	-	68	-	-	-	25
Due to (from) other funds	-	-	-	-	-	-
Debt	831	923	3,591	-	7,180	144
Total Restricted Liabilities	**122,574**	**997**	**3,612**	**-**	**8,101**	**173**
Invested in Capital Assets	238,026	112,276	88,644	19,350	62,095	7,954
Externally Restricted	741	172	4,308	1,210	4,741	416
Internally Restricted	3,257	22,418	2,570	1,113	3,362	974
Unrestricted	-	-	-	-	-	-
Restricted Fund Balance	**242,024**	**134,866**	**95,522**	**21,673**	**70,198**	**9,344**
Total Liabilities and Restricted Fund Balance	**364,598**	**135,863**	**99,134**	**21,673**	**78,298**	**9,518**

STATEMENT OF OPERATIONS AND CHANGE IN FUND BALANCES	Prairie North	Prince Albert Parkland	Regina Qu'Appelle	Saskatoon	Sun Country	Sunrise	Grand Total
Restricted Revenues:							
Ministry of Health - General Revenue Fund	3,180	1,741	19,906	18,752	2,327	1,711	59,969
Other Government of Saskatchewan	-	-	343	3,155	31	-	3,901
Federal Government revenue	50	-	-	-	-	-	50
Funding from other Provinces	264	-	-	-	-	-	264
Donations	2,432	923	1,378	5,833	218	823	17,132
Ancillary Operations - income	-	-	-	-	-	-	21
Investment Income	63	133	18	1,374	41	39	2,066
Recoveries	-	-	-	-	93	-	184
Other Revenue	60	174	130	4,526	(72)	88	7,564
Total Restricted Revenue	**6,049**	**2,971**	**21,775**	**33,640**	**2,638**	**2,661**	**91,151**
Restricted Expenses:							
Inpatient & resident services							
Nursing Administration	-	525	-	-	-	3	1,265
Acute	4,602	2,665	9,572	-	355	442	22,596
Supportive	1,245	1,350	1,455	-	3,258	570	17,741
Integrated	-	-	502	-	2,267	-	10,421
Rehabilitation	-	-	532	-	-	-	532
Mental health & addictions	62	5	-	-	-	6	100
Total inpatient & resident services	**5,909**	**4,545**	**12,061**	**-**	**5,880**	**1,021**	**52,655**
Physician compensation	**-**	**1**	**-**	**-**	**-**	**-**	**1**
Ambulatory care services	**-**	**149**	**287**	**-**	**-**	**31**	**1,095**
Diagnostic & therapeutic services	**-**	**680**	**16**	**-**	**7**	**616**	**4,698**
Community health services							-
Primary health care	92	4	285	-	56	33	492
Home care	81	15	10	-	9	15	526
Mental health & addictions	-	344	6	-	1	5	369
Population health	5	40	21	-	62	10	172
Emergency response services	120	147	1,333	-	317	53	3,014
Other community services	-	-	-	-	-	1	68
Total community health services	**298**	**550**	**1,655**	**-**	**445**	**117**	**4,641**
Support services							-
Program support	1,995	39	1,600	41,592	-	15	46,169
Operational support	-	514	15,958	-	-	181	18,205
Other support	-	202	-	-	-	5,415	9,664
Total support services	**1,995**	**755**	**17,558**	**41,592**	**-**	**5,611**	**74,038**
Ancillary	**-**	**51**	**146**	**-**	**-**	**13**	**213**
Total Restricted Expenses	**8,202**	**6,731**	**31,723**	**41,592**	**6,332**	**7,409**	**137,341**
Restricted Fund Excess/(Deficiency)	**(2,153)**	**(3,760)**	**(9,948)**	**(7,952)**	**(3,694)**	**(4,748)**	**(46,190)**
Interfund Transfers	4,507	946	370	1,015	929	1,990	24,868
Other Transfers	-	-	(286)	-	-	-	(286)
Increase (decrease) in fund balances	**2,354**	**(2,814)**	**(9,864)**	**(6,937)**	**(2,765)**	**(2,758)**	**(21,608)**
Restricted Fund Balance - Beginning of the year	68,776	110,648	308,472	463,948	96,356	60,166	1,680,812
Restricted Fund Balance - End of Year	**71,130**	**107,834**	**298,608**	**457,011**	**93,591**	**57,408**	**1,659,204**
STATEMENT OF FINANCIAL POSITION							
Restricted Assets:							
Cash and Short-term Investments	9,198	9,169	388	69,117	7,449	3,232	139,728
Accounts Receivable:							
Ministry of Health	1,084	631	-	23	2	-	109,872
Other	442	239	1,101	1,421	43	67	20,503
Prepaid Expenses	-	-	-	-	-	1,648	1,648
Due From (Community Trust Fund)	-	-	20,613	-	(117)	-	20,496
Investments	85	-	529	-	3	-	2,145
Capital Assets	67,381	104,460	283,468	446,677	88,918	64,396	1,596,203
Other Assets	-	554	-	-	-	-	710
Total Restricted Assets	**78,190**	**115,053**	**306,099**	**517,238**	**96,298**	**69,343**	**1,891,305**
Liabilities and Restricted Fund Balance:							
Accounts Payable	40	551	814	11,329	187	-	13,873
Accrued Liabilities	-	-	-	-	-	15	121,758
Deferred Revenue (Non-Ministry of Health)	-	-	-	-	-	-	93
Due to (from) other funds	-	-	-	-	-	-	-
Debt	7,000	6,668	6,677	48,898	2,519	11,918	96,349
Total Restricted Liabilities	**7,040**	**7,219**	**7,491**	**60,227**	**2,706**	**11,933**	**232,073**
Invested in Capital Assets	60,381	97,792	276,791	396,235	86,212	52,478	1,498,234
Externally Restricted	4,068	4,730	20,890	60,692	6,004	1,966	109,938
Internally Restricted	6,701	5,312	927	84	1,375	2,966	51,059
Unrestricted	-	-	-	-	-	-	-
Restricted Fund Balance	**71,150**	**107,834**	**298,608**	**457,011**	**93,591**	**57,410**	**1,659,231**
Total Liabilities and Restricted Fund Balance	**78,190**	**115,053**	**306,099**	**517,238**	**96,298**	**69,343**	**1,891,304**

[1] The restricted fund consists of the Capital Fund and Community Trust Fund. The Capital Fund reflects the equity of the RHA on capital assets and any associated long-term debt. The Capital Fund revenue includes revenue from the General Revenue Fund provided for construction of capital projects and/or the acquisition of capital assets. Expenses consist mainly of amortization expense. The Community Trust Fund reflects community-generated assets transferred to the RHA by amalgamating health corporations. The assets include cash and investments initially accumulated by the health corporations from donations or municipal tax levies.

[2] Some items may not balance due to rounding.

Operating Fund Financial Statements[1] (In 000s Dollars)

SCHEDULE OF EXPENSES BY OBJECT	Cypress	Five Hills	Heartland	Keewatin Yatthé	Kelsey Trail	Mamawetan Churchill River
Operating Expenses:						
Advertising & Public Relations	24	49	45	8	37	28
Board costs	60	43	42	89	59	98
Compensation - benefits	15,510	14,447	13,381	3,914	15,887	4,696
Compensation - employee future benefits	56	21	70	-	42	26
Compensation - salaries	81,627	72,983	70,391	19,724	78,285	17,420
Continuing Education Fees & Materials	339	129	155	175	164	173
Contracted-out Services - Other	3,736	2,195	884	240	253	1,379
Diagnostic imaging supplies	79	169	23	2	5	2
Dietary Supplies	34	155	119	44	155	1
Drugs	1,456	1,591	708	150	702	253
Environmental remediation	-	-	-	-	-	-
Food	2,159	1,452	1,582	266	1,883	226
Grants to ambulance services	2,022	3,236	133	-	3,657	1,450
Grants to Health Care Organizations & Affiliates	2,218	29,698	3,014	185	785	259
Housekeeping and laundry supplies	982	678	644	16	355	29
Information technology contracts	898	1,017	573	40	908	205
Insurance	457	233	394	93	243	47
Interest	17	12	35	-	201	4
Laboratory supplies	1,129	1,042	774	177	1,089	146
Medical and surgical supplies	3,178	2,855	1,350	415	2,937	385
Medical remuneration and benefits	14,524	16,625	3,013	-	10,110	611
Meeting Expense	-	4	9	-	66	19
Office supplies and other office costs	1,040	607	594	472	459	371
Other	362	20	630	120	768	323
Professional fees	843	828	984	773	1,099	238
Prosthetics	156	673	-	-	-	-
Purchased salaries	760	588	383	1,159	640	439
Rent/lease/purchase costs	938	1,476	951	989	1,456	837
Repairs and maintenance	3,272	1,528	2,694	670	1,499	383
Supplies - Other	215	121	235	52	366	206
Therapeutic Supplies	-	100	24	-	-	-
Travel	1,062	1,066	803	559	1,302	632
Utilities	2,188	1,838	1,797	408	2,067	246
Total Operating Expenses	**141,341**	**157,479**	**106,434**	**30,740**	**127,479**	**31,131**
Restricted Expenses:						
Amortization	8,716	8,794	5,387	1,215	4,778	706
Loss/(gain) on disposal of fixed assets	590	-	(76)	-	84	-
Mortgage interest	3,901	79	41	-	97	-
Other	100	380	112	-	46	400
Total Restricted Expenses	**13,307**	**9,253**	**5,464**	**1,215**	**5,005**	**1,106**
Total Operating and Restricted Expenses	**154,648**	**166,732**	**111,898**	**31,955**	**132,484**	**32,237**

SCHEDULE OF EXPENSES BY OBJECT	Prairie North	Prince Albert Parkland	Regina Qu'Appelle	Saskatoon	Sun Country	Sunrise	Grand Total
Operating Expenses:							
Advertising & Public Relations	72	61	146	162	105	164	901
Board costs	95	81	65	33	70	83	818
Compensation - benefits	33,104	27,477	114,051	127,289	17,563	27,982	415,300
Compensation - employee future benefits	240	198	583	-	3	-	1,239
Compensation - salaries	168,607	138,305	569,277	619,566	87,679	143,325	2,067,189
Continuing Education Fees & Materials	390	174	696	985	153	268	3,801
Contracted-out Services - Other	6,328	3,209	26,169	29,713	2,057	1,809	77,972
Diagnostic imaging supplies	251	82	577	3,214	5	98	4,507
Dietary Supplies	287	141	77	251	133	328	1,725
Drugs	3,224	2,555	15,142	33,369	433	2,207	61,790
Environmental remediation	-	-	-	-	-	-	-
Food	4,156	2,691	8,398	8,446	1,508	3,222	35,989
Grants to ambulance services	3,742	4,481	3,355	16,830	575	3,784	43,265
Grants to Health Care Organizations & Affiliates	7,183	10,433	67,363	116,656	24,084	2,536	264,414
Housekeeping and laundry supplies	1,360	1,215	2,564	4,596	282	1,347	14,068
Information technology contracts	2,509	776	6,399	4,969	706	1,828	20,828
Insurance	404	347	1,772	1,686	585	425	6,686
Interest	33	27	417	3,039	19	289	4,093
Laboratory supplies	1,967	1,401	6,406	10,386	516	1,309	26,342
Medical and surgical supplies	8,078	5,787	48,560	58,921	1,895	4,088	138,449
Medical remuneration and benefits	22,675	25,092	94,720	134,198	7,336	12,499	341,403
Meeting Expense	59	27	171	67	47	63	532
Office supplies and other office costs	2,023	757	3,530	5,686	801	1,525	17,865
Other	4,420	511	7,327	1,694	435	352	16,962
Professional fees	1,596	1,348	14,122	1,689	2,367	1,373	27,260
Prosthetics	296	1,596	18,793	19,417	-	99	41,030
Purchased salaries	1,828	3,569	358	7,129	676	607	18,136
Rent/lease/purchase costs	1,835	1,838	13,491	11,415	868	4,060	40,154
Repairs and maintenance	4,827	2,179	14,625	21,076	2,795	2,888	58,436
Supplies - Other	1,400	978	3,836	2,667	314	460	10,850
Therapeutic Supplies	3	134	886	406	87	142	1,782
Travel	1,692	1,828	4,353	4,518	991	2,373	21,179
Utilities	3,729	2,589	11,873	14,172	2,185	3,104	46,196
Total Operating Expenses	**288,413**	**241,887**	**1,060,102**	**1,264,245**	**157,273**	**224,637**	**3,831,161**
Restricted Expenses:							
Amortization	7,904	6,379	29,739	37,546	4,208	6,956	122,328
Loss/(gain) on disposal of fixed assets	-	36	176	-	72	-	882
Mortgage interest	265	102	125	1,292	79	452	6,433
Other	33	215	1,683	2,754	2,045	1	7,769
Total Restricted Expenses	**8,202**	**6,732**	**31,723**	**41,592**	**6,404**	**7,409**	**137,412**
Total Operating and Restricted Expenses	**296,615**	**248,619**	**1,091,825**	**1,305,837**	**163,677**	**232,046**	**3,968,573**

[1] Some items may not balance due to rounding.

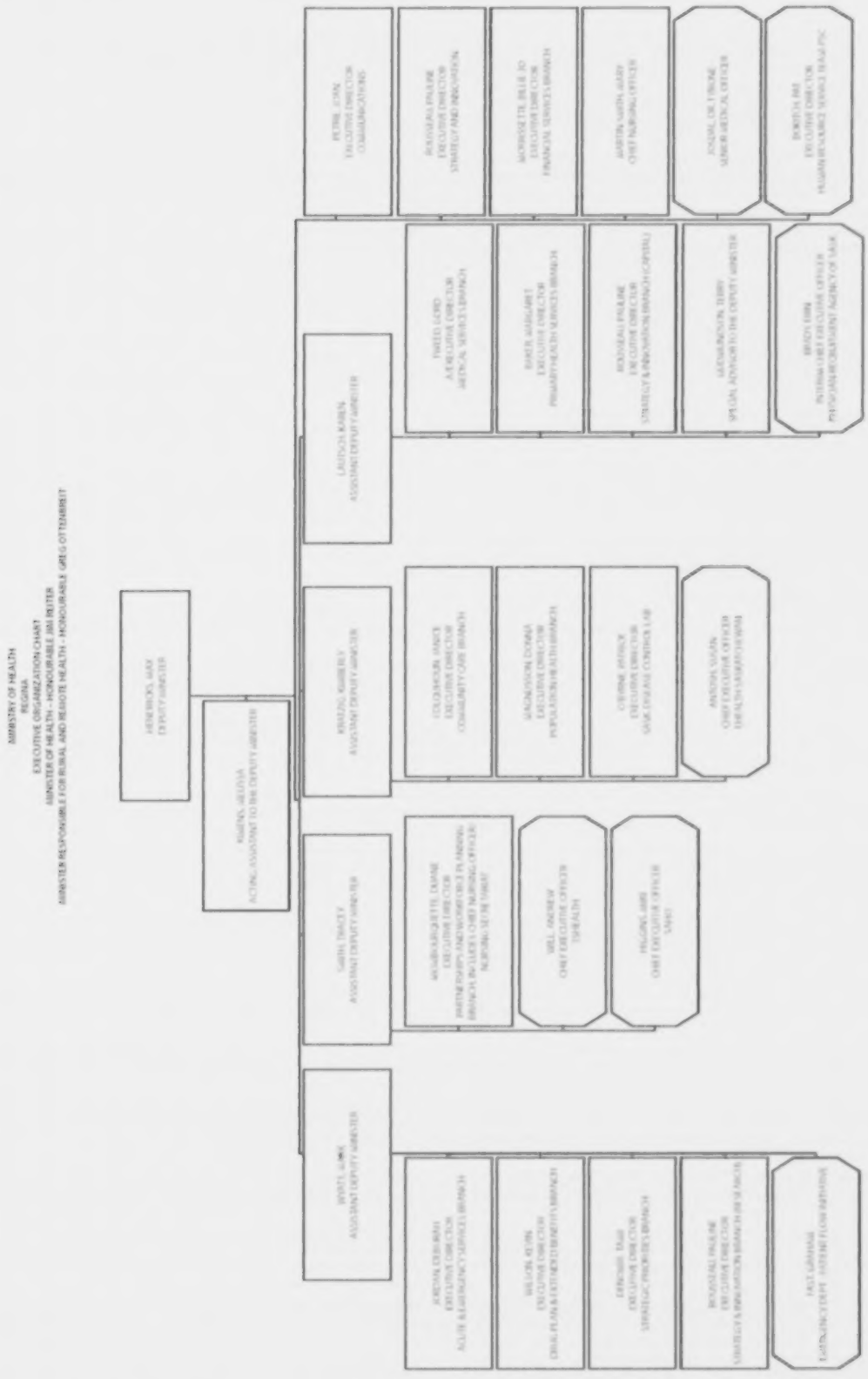
For More Information

This annual report is available online at www.saskatchewan.ca/government/government-structure/ministries/health.

Please visit the Government of Saskatchewan website at www.saskatchewan.ca/residents/health for more information on the Government of Saskatchewan's programs and services.

Contact information for Ministry of Health programs and services can also be found in Appendix III of this report called Saskatchewan Ministry of Health - Directory of Services (page 49).

Appendix I: Ministry of Health Executive Organizational Chart


MINISTRY OF HEALTH
REGINA
EXECUTIVE ORGANIZATION CHART
MINISTER OF HEALTH - HONOURABLE JIM REITER
MINISTER RESPONSIBLE FOR RURAL AND REMOTE HEALTH - HONOURABLE GREG OTTENBREIT

Appendix II: Critical Incidents Summary

Saskatchewan was the first jurisdiction in Canada to formalize critical incident reporting through legislation that came into force on September 15, 2004.

A "critical incident" is defined in the *Saskatchewan Critical Incident Reporting Guideline, 2004* as "a serious adverse health event including, but not limited to, the actual or potential loss of life, limb or function related to a health service provided by, or a program operated by, a regional health authority (RHA) or health care organization (HCO)." With legislative changes enacted in 2007, reporting of critical incidents also became mandatory for the Saskatchewan Cancer Agency (SCA). In addition to the definition of critical incident, the *Saskatchewan Critical Incident Reporting Guideline, 2004* contains a specific list of events that are to be reported to the Ministry of Health.

The province has an established network of professionals in place within health regions and the SCA who identify events where a patient is harmed (or where there is a potential for harm), report de-identified information to the Provincial Quality of Care Coordinators (PQCCs) in the Ministry of Health, conduct an investigation, and implement necessary changes. Arising out of their review of critical incidents, health regions and the SCA generate recommendations for improvement that they are then responsible for implementing.

The role of the PQCCs is to aggregate, analyze, and report on critical incident data, and broadly disseminate applicable system improvement opportunities. The PQCCs also provide advice and support to RHAs and the SCA in their investigation and review of critical incidents.

During 2016/17, a total of 186 critical incidents were reported to the Ministry of Health, a 25.3 per cent decrease compared to 2015/16 when 249 critical incidents were reported. The number of incidents reported in 2016/17 was the lowest in the past five years. A change in the number of reported critical incidents, either more or fewer reports, may be because of a change in the actual number of critical incidents occurring, or it could be due to awareness of, and compliance with, the legislation and regulations, as well as the event reporting system in use (such as Safety Alert/Stop the Line) and the culture of safety present at every level of the health care organization.

Delivery of health care services is a complex process involving many inter-related systems and activities. The formal critical incident reporting process has the potential to increase patient safety by reducing or eliminating the recurrence of similar critical incidents in Saskatchewan through implementation of targeted recommendations which address the underlying, or root causes, of critical incidents. Monitoring of critical incidents can also be used to direct region-wide patient safety and improvement initiatives. When recommendations are broadly applicable, a patient safety alert may be issued and distributed to a provincial network of Quality of Care Coordinators, risk managers, health providers, and health senior leaders. In 2016/17, eight patient safety alerts were issued and posted to https://www.ehealthsask.ca/services/resources/Pages/Safety-Alerts.aspx

These tables show the number of critical incidents reported by category and subcategory for the past five years.

Category	2016/17	2015/16	2014/15	2013/14	2012/13
I. Surgical Events					
a) Surgery performed on wrong body part	0	1	0	0	1
b) Surgery performed on the wrong patient	0	1	0	0	0
c) The wrong surgical procedure performed on a patient	1	0	0	2	1
d) Retention of a foreign object in a patient after surgery or other procedure	3	6	4	3	8
e) Death during or immediately after surgery of a normal, healthy patient, or of a patient with mild systemic disease	0	0	0	1	1
f) Unintentional awareness during surgery with recall by the patient	0	0	0	0	1
g) Other surgical event	4	11	4	6	5
Total	**8**	**19**	**8**	**12**	**17**

Category	2016/17	2015/16	2014/15	2013/14	2012/13
II. Product and Device Events					
a) Contaminated drugs, devices, or biologics provided by the RHA/HCO	0	0	1	3	6
b) Use or function of a device in patient care in which the device is used or functions other than as intended	5	3	5	2	3
c) Intravascular air embolism	0	0	0	0	0
d) Other product or device event	1	5	4	6	3
Total	**6**	**8**	**10**	**11**	**12**

Category	2016/17	2015/16	2014/15	2013/14	2012/13
III. Patient Protection Events					
a) An infant discharged to the wrong person	0	0	0	0	0
b) Patient disappearance	1	10	10	8	1
c) Patient suicide or attempted suicide	10	24	15	17	6
d) Other patient protection event	4	14	5	2	3
Total	**15**	**48**	**30**	**27**	**10**

Category	2016/17	2015/16	2014/15	2013/14	2012/13
IV. Care Management Events					
a) Medication or fluid error	17	20	19	22	18
b) Hemolytic reaction due to the administration of ABO-incompatible blood or blood products	0	0	0	4	1
c) Maternal death or serious disability	0	3	3	2	2
d) Full-term fetal or neonatal death or serious disability	4	4	9	10	7
e) Hypoglycemia while in the care of the RHA/HCO	1	0	0	0	0
f) Neonatal death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia	1	0	0	0	0
g) Stage 3 or 4 pressure ulcers acquired after admission to a facility	20	17	7	10	9
h) Delay or failure to transfer	3	1	5	3	0
i) Error in diagnosis	13	25	7	19	6
j) Other care management issues	42	56	49	31	37
Total	**101**	**126**	**99**	**101**	**80**

Category	2016/17	2015/16	2014/15	2013/14	2012/13
V. Environmental Events					
a) Electric shock while in the care of the RHA/HCO	0	0	0	0	0
b) Oxygen or other gas contains the wrong gas or is contaminated by toxic substances	0	0	0	0	0
c) Burn from any source	0	0	0	1	3
d) Patient death associated with a fall	35	36	21	20	17
e) Use or lack of restraints or bed rails	3	0	0	7	4
f) Failure or de-activation of exit alarms or environmental monitoring devices	1	0	1	2	0
g) Transport arranged or provided by the RHA/HCO	0	0	0	1	4
h) Delay or failure to reach a patient for emergent or scheduled services	3	5	9	2	6
i) Other environmental event	7	3	3	4	2
Total	**49**	**44**	**34**	**37**	**36**

Category	2016/17	2015/16	2014/15	2013/14	2012/13
VI. Criminal Events					
a) Care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider	0	0	0	0	0
b) Abduction of a patient of any age	0	0	0	1	0
c) Sexual assault of a patient	0	2	5	0	3
d) Physical assault of a patient within or on grounds owned or controlled by the RHA/HCO	2	1	3	3	0
e) Sexual or physical assault of a patient perpetrated by an employee	1	0	1	1	1
f) Other criminal event	4	1	4	1	0
Total	**7**	**4**	**13**	**6**	**4**
Total CIs Reported	**186**	**249**	**194**	**194****	**159****

*** Note: Numbers with a double asterisk have changed between the 2013/14 Annual Report and the 2014/15 Annual Report publications as occasionally cases initially reported to the Ministry of Health are later determined to not meet the definition of critical incident and are removed from the total.*

Appendix III: Contact information for Ministry of Health Programs and Services

Regional Health Authorities

www.saskatchewan.ca/residents/health/understanding-the-health-care-system/saskatchewan-health-regions/health-region-contact-information-and-websites

Regional Health Authority offices:

Athabasca Health Authority	(306) 439-2200
Cypress Regional Health Authority	(306) 778-5100
Five Hills Regional Health Authority	(306) 694-0296
Heartland Regional Health Authority	(306) 882-4111
Keewatin Yatthé Regional Health Authority	(306) 235-2220
Kelsey Trail Regional Health Authority	(306) 873-6600
Mamawetan Churchill River Regional Health Authority	(306) 425-2422
Prairie North Regional Health Authority	(306) 446-6606
Prince Albert Parkland Regional Health Authority	(306) 765-6600
Regina Qu'Appelle Regional Health Authority	(306) 766-7777
Regina Qu'Appelle Regional Health Authority Hospitals	(306) 766-5100
Saskatoon Regional Health Authority	(306) 655-3300
Sun Country Regional Health Authority	(306) 842-8399
Sunrise Regional Health Authority	(306) 786-0100

Saskatchewan Cancer Agency

(639) 625-2010

Saskatchewan Health Card Applications

To apply for a Saskatchewan Health Services Card, report changes to personal or registration information, or for more information about health registration:

Phone	306-787-3251 1-800-667-7551 (toll-free Canada & US)
Email	change@ehealthsask.ca

Vital Statistics

Phone	306-787-3251 1-800-667-7551 (toll-free Canada & US)
Email	vitalstatistics@ehealthsask.ca

Health Services Cards:

Email	change@ehealthsask.ca

Apply online or update personal information for a Saskatchewan Health Services Card at www.ehealthsask.ca/residents/health-cards/Pages/Apply-for-a-Health-Card.aspx

HealthLine

For health information from a registered nurse 24 hours a day.

Phone	811
TTY Access	1-888-425-4444

HealthLine Online

www.saskatchewan.ca/residents/health/accessing-health-care-services/healthline

Problem Gambling Help Line

1-800-306-6789

Smokers' HelpLine

1-877-513-5333
www.smokershelpline.ca

Saskatchewan Air Ambulance program:

24-Hour Emergency	Call 9-1-1
Physicians or Designates should call	1-306-933-5255 or 1-888-782-8247

www.saskatchewan.ca/residents/health/emergency-medical-services/ambulance-services

Supplementary Health Program:

Regina	(306) 787-3124
Toll-Free within Saskatchewan	1-800-266-0695

www.saskatchewan.ca/residents/health/prescription-drug-plans-and-health-coverage/extended-benefits-and-drug-plan/supplementary-health-benefits

Family Health Benefits

For eligibility and to apply:

Regina	(306) 787-4723
Toll-Free	1-888-488-6385

For information on what is covered:

Regina	(306) 787-3124
Toll-Free	1-800-266-0695

www.saskatchewan.ca/residents/health/prescription-drug-plans-and-health-coverage/extended-benefits-and-drug-plan/family-health-benefits

Special Support Applications for Prescription Drug Costs

To apply:
www.saskatchewan.ca/residents/health/prescription-drug-plans-and-health-coverage/extended-benefits-and-drug-plan/special-support-program

Applications also available at all Saskatchewan pharmacies.

For inquiries:

Regina	(306) 787-3317
Toll-Free within Saskatchewan	1-800-667-7581

Emergency Assistance for Prescription Drugs

Residents who require immediate treatment with covered prescription drugs and are unable to cover their share of the cost may access a one-time emergency assistance.

www.saskatchewan.ca/residents/health/prescription-drug-plans-and-health-coverage/extended-benefits-and-drug-plan/emergency-assistance-for-prescription-drugs

Saskatchewan Aids to Independent Living (SAIL)

Regina	(306) 787-7121
Toll Free	1-888-787-8996
Email	dp.sys.support@health.gov.sk.ca

www.saskatchewan.ca/residents/health/accessing-health-care-services/health-services-for-people-with-disabilities/sail

Out-of-province health services

Regina	(306) 787-3475
Toll-Free within Saskatchewan	1-800-667-7523

www.saskatchewan.ca/residents/health/prescription-drug-plans-and-health-coverage/health-benefits-coverage/out-of-province-and-out-of-canada-coverage

To obtain refunds for out-of-province physician and hospital services, forward bills to:

Medical Services Branch
Ministry of Health
3475 Albert Street
Regina SK S4S 6X6

Prescription Drug Program

Regina	(306) 787-3317
Toll-Free within Saskatchewan	1-800-667-7581

To obtain refunds for out-of-province drug costs, forward bills to:

Drug Plan and Extended Benefits Branch
Ministry of Health
3475 Albert Street
Regina SK S4S 6X6

Appendix IV: Summary of Health Legislation

The Ambulance Act

The Act regulates emergency medical service personnel and the licensing and operation of ambulance services.

The Cancer Agency Act

The Act sets out the funding relationship between Saskatchewan Health and the Saskatchewan Cancer Agency and its responsibility to provide cancer-related services.

The Change of Name Act, 1995

An Act respecting Changes of Name.

The Chiropractic Act, 1994

The Act regulates the chiropractic profession in the province.

The Dental Disciplines Act

The Act regulates the six dental professions of dentistry, dental hygiene, dental therapists, dental assistants, denturists and dental technicians.

The Dieticians Act

The Act regulates dieticians in the province.

The Emergency Medical Aid Act

The Act provides protection from liability for physicians, nurses and others when they are providing, in good faith, emergency care outside a hospital or place with adequate facilities or equipment.

The Family and Community Services Act

This Act authorizes the Minister to undertake any action needed to promote the growth and development of family and community services and resources.

The Fetal Alcohol Syndrome Awareness Day Act

The Act establishes that September 9th of each year is designated as Fetal Alcohol Syndrome Awareness Day.

The Health Administration Act

The Act provides the legal authority for the Minister of Health to make expenditures, undertake research, create committees, operate laboratories and conduct other activities for the benefit of the health system.

The Health Districts Act

Most of the provisions within this Act have been repealed with the proclamation of most sections of *The Regional Health Services Act*. Provisions have been incorporated with regard to payments by amalgamated corporations to municipalities.

The Health Facilities Licensing Act

The Act governs the establishment and regulation of health facilities such as non-hospital surgical clinics.

The Health Information Protection Act

The Act protects personal health information in the health system in Saskatchewan and establishes a common set of rules that emphasize the protection of privacy, while ensuring that information is available to provide efficient health services.

The Health Quality Council Act

The Act governs the Health Quality Council, which is an independent, knowledgeable voice that provides objective, timely, evidence informed information and advice for achieving the best possible health care using available resources within the province.

The Hearing Aid Sales and Services Act

The Act regulates private businesses involved in the testing of hearing and the selling of hearing aids.

The Human Resources, Labour and Employment Act (with respect to section 4.02)

An Act respecting human resources, labour and employment.

The Human Tissue Gift Act

The Act regulates organ donations in the province.

The Licensed Practical Nurses Act, 2000

The Act regulates licensed practical nurses in the province.

The Medical Laboratory Licensing Act, 1994

The Act governs the operation of medical laboratories in the province.

The Medical Laboratory Technologists Act

The Act regulates the profession of medical laboratory technology.

The Medical Profession Act, 1981

The Act regulates the profession of physicians and surgeons.

The Medical Radiation Technologists Act, 2006

The Act regulates the profession of medical radiation technology.

The Mental Health Services Act

The Act regulates the provision of mental health services in the province and the protection of persons with mental disorders.

The Midwifery Act

The Act regulates midwives in the province.

The Naturopathy Act

The Act regulates naturopathic practitioners in Saskatchewan.

The Occupational Therapists Act, 1997

The Act regulates the profession of occupational therapy.

The Opticians Act

The Act regulates opticians (formally known as ophthalmic dispensers) in the province.

The Optometry Act, 1985

The Act regulates the profession of optometry.

The Paramedics Act

The Act regulates paramedics and emergency medical technicians in the province.

The Patient Choice Medical Imaging Act

The Act regulates the licensing and operation of certain facilities providing medical imaging services.

The Personal Care Homes Act

The Act regulates the establishment, size, and standards of services of personal care homes.

The Pharmacy and Pharmacy Disciplines Act

An Act respecting pharmacists, pharmacy technicians, pharmacies and drugs.

The Physical Therapists Act, 1998

The Act regulates the profession of physical therapy.

The Podiatry Act

The Act regulates the podiatry profession.

The Prescription Drugs Act

The Act provides authority for the provincial drug plan and the collection of data for all drugs dispensed within the province.

The Prostate Cancer Awareness Month Act

The Act raises awareness of prostate cancer in Saskatchewan.

The Psychologists Act, 1997

The Act regulates psychologists in Saskatchewan.

The Public Health Act

Sections 85-88 of this Act remain in force in order that governing boards of some facilities can continue to operate.

The Public Health Act, 1994

The Act provides authority for the establishment of public health standards, such as public health inspection of food services.

The Public Works and Services Act
(with respect to clauses 4(2)(a) to (g), (i) to (l), (n) and (o) and section 8)

An Act respecting public works and the provision of supplies and services.

The Regional Health Services Act

The Act addresses the governance and accountability of the regional health authorities, establishes standards for the operation of various health programs and repeals *The Health Districts Act*, *The Hospital Standards Act*, and *The Housing and Special-care Homes Act*.

The Registered Nurses Act, 1988

The Act regulates registered nurses in Saskatchewan.

The Registered Psychiatric Nurses Act

The Act regulates the profession of registered psychiatric nursing.

The Residential Services Act

The Act governs the establishment and regulation of facilities that provide certain residential services. The act is jointly assigned to the Minister of Health, the Minister of Justice and Attorney Journal, and the Minister of Social Services.

The Respiratory Therapists Act

The Act regulates the profession of respiratory therapists.

The Saskatchewan Health Research Foundation Act

The Act governs the Saskatchewan Health Research Foundation, which designs, implements, manages, and evaluates funding programs to support a balanced array of health research in Saskatchewan.

The Saskatchewan Medical Care Insurance Act

The Act provides the authority for the province's medical care insurance program and payments to physicians.

The Speech-Language Pathologists and Audiologists Act

The Act regulates speech-language pathologists and audiologists in the province.

The Tobacco Control Act

This Act controls the sale and use of tobacco and tobacco related products and allows for making consequential amendments to other Acts.

The Tobacco Damages and Health Care Costs Recovery Act

The Act is intended to enhance the prospect of successfully suing tobacco manufacturers for the recovery of tobacco related health care costs. It was proclaimed in force and became law in May 2012.

The Vital Statistics Act, 2009

This Act provides authority for the keeping of vital statistics and making consequential amendments to other Acts.

The Vital Statistics Administration Transfer Act

This Act transfers the administration of *The Vital Statistics Act, 1995*, *The Change of Name Act, 1995* and other statutory duties of the Director of Vital Statistics to eHealth Saskatchewan.

The White Cane Act

The Act sets out the province's responsibilities with respect to services for the visually impaired.

The Youth Drug Detoxification and Stabilization Act

The Act provides authority to detain youth who are suffering from severe drug addiction/abuse.

Appendix V: New Legislation in 2016-17

One new Act was passed in 2016-17.

The Patient Choice Medical Imaging Act

The new legislation received Royal Assent and is proclaimed in force. Specifically, the legislation is an Act respecting the licensing and operation of certain facilities providing Medical Imaging Services, repealing a certain Act and making consequential amendments to certain Acts. The legislation:

- Allows patients to pay for Magnetic Resonance Imaging (MRI) services while allowing for the addition of private pay Computed Tomography (CT) scans obtained in licensed private facilities in Saskatchewan.
- Allow for the addition of other medical imaging modalities to be added in the future through regulatory amendments.

One new Act was introduced in 2016-17.

The Provincial Health Authority Act

BILL No. 53: An Act respecting the Provincial Health Authority and Health Services and making consequential amendments to other legislation as required. The legislation will:

- enable the consolidation of the existing 12 Regional Health Authorities (RHAs) into one Provincial Health Authority (PHA); and
- Repeal *The Regional Health Services Act*.

Appendix VI: Legislative Amendments and Proclamations in 2016-17

Two Acts were introduced for amendment in 2016-17.

The Cancer Agency Amendment Act, 2016

The new legislation received Royal Assent and is proclaimed in force. *The Cancer Agency Act* provides the Saskatchewan Cancer Agency (SCA) with responsibility for the planning, organization, delivery and evaluation of cancer control services throughout Saskatchewan. Specifically, the amendments:

- Provide statutory support to the Saskatchewan Cancer Agency (SCA) to require and collect information from other organizations regarding the cancer control services provided to individuals;
- Affirm the SCA's ability to report information;
- Ensure the terminology used is consistent with the services provided by the SCA;
- Clarify the applicable legislative authority for the SCA to enter into agreements; and
- Amend the definitions used in the interpretation section to reflect the current practice and government structure.

The Public Health (Miscellaneous) Amendment Act, 2016

The new legislation received Royal Assent. Specifically, the amendments:

- Enable public access to public health inspection reports;
- Modify the definition for "clinic nurse" to include nurses that have been granted appropriate rights and privileges;
- Update the definition section to include "nurse practitioner";
- make reference to Nurse Practitioners (NPs) in sections requiring the reporting and follow-up of communicable diseases; and
- Make minor housekeeping amendments.

Two Acts were proclaimed in 2016-17.

The Health Information Protection Amendment Act, 2015

Amendments to *The Health Information Protection Amendment Act, 2015* (HIPA) received Royal Assent and are proclaimed in force. Specifically, the amendments:

- Include the addition of a strict liability offence to establish that if a trustee "knowingly" violated the Act they would be guilty of an offence.
- Clarifies the ability to lay a charge against an employee of a trustee under the Act where that employee has knowingly disclosed personal health information.
- Add a snooping offence which applies in instances where personal health information is intentionally accessed by a party who knows that the information is not reasonably required to carry out a purpose authorized under HIPA.
- Allow the Minister to appoint a person or body to take control or custody of records where an active trustee has failed to secure the records. This allows for a quicker response to the discovery of abandoned patient records.

The Prescription Drugs Amendment Act, 2010

Amendments to *The Prescription Drugs Amendment Act, 2010* received Royal Assent and are proclaimed in force. Specifically, the amendments:

- Allow the Minister to designate non-prescription drugs under *The Prescription Drugs Act* through regulations that will ensure the capture of personal health information into the Pharmaceutical Information Program from the sale of the designated drugs to Saskatchewan residents.

Appendix VII: New Regulations in 2016-17

One new set of regulations was created in 2016-17.

The Medical Imaging Facilities Licensing Regulations

These regulations were developed to:

- Ensure that all aspects of magnetic resonance imaging (MRI) and/or (computed tomography) CT services provided in the MRI and/or CT facility are provided in accordance with generally accepted standards of the accreditation program.
- Outline the criteria by which MRI and/or CT Services are performed under the continuous supervision of a Medical Director, who is a duly qualified medical practitioner that has been recognized by the College of Physicians and Surgeons of Saskatchewan.
- Outline the CT/MRI Facilities Accreditation Program, established by the College of Physicians and Surgeons of Saskatchewan is the accreditation program operator for the MRI and/or CT facilities.
- Require the Regional Health Authority, an affiliate or the Saskatchewan Cancer Agency to report on the anticipated impact of the MRI and/or CT facility on the public systems operations and if there would be any sustained adverse effect on the ability to provide publicly funded medical imaging services prior to the issuance of a license.
- Ensure there is also a benefit to the public system by requiring private vendors to provide a second scan, free of charge, to an individual waiting on the public list every time a person chooses to pay privately for MRI or CT services.
- Allow the Minister to outline the terms and conditions of a licence under which the MRI and/or CT facility must operate.

Appendix VIII: Regulatory Amendments in 2015-16

Eight regulations were amended in 2016-17.

The Public Accommodation (Miscellaneous) Amendment Regulations, 2016

Amendments to the regulations contain provisions that address:

- The operation and maintenance requirements at rental units and/or itinerant use accommodations such as hotels, motels, campgrounds, bed and breakfast (B&B) facilities and similar short term accommodations.
- The approval and licensing of hotels, motels, apartment hotels, vacation farms, B&B facilities, campgrounds, recreational camps (e.g. church camps), rental cabins, and outfitters.
- Safe water supplies, washroom facilities, sewage disposal, and garbage collection.
- Pest control.
- Ventilation, lighting and minimum temperature requirements.
- Client registration.

The Food Safety Amendment Regulations, 2016

These amendments were developed to:

- Replace *The Public Eating Establishment Regulations* (1988), *The Bakeshop Regulations* (1986) and the food safety provisions in *The Sanitation Regulations* (1964). Having requirements in one regulation ensures consistent application of requirements across different types of facilities.
- Reflect more up-to-date standards that are being adopted in other provinces.

The Saskatchewan Medical Care Insurance Payment (Physician Services) Amendment Regulations, 2016

Amendments to *The Saskatchewan Medical Care Insurance Payment Regulations, 1994* provide the authority to pay:

- Negotiated and approved rates and new insured services within an existing agreement with the Saskatchewan Medical Association.

The Mental Health Services (Regional Psychiatric Centre) Amendment Regulations, 2017

Amendments to *The Mental Health Services Regulations* were developed to:

- Ensure persons in the care and custody of the Correctional Services of Canada who require involuntary mental health care receive timely access to mental health services.

The Medical Care Insurance Beneficiary and Administration (CT and MRI Services) Amendment Regulations, 2017

Amendments to the regulations were a required consequential amendment alongside the proclamation of *The Patient Choice Medical Imaging Act* and regulations. *The Medical Care Insurance Beneficiary and Administration (MCIBA) Regulations* currently stipulates MRI services to be uninsured services. This amendment will:

- Remove MRI services as being defined by the MRI Facilities Licensing Regulations, which is to be repealed alongside the proclamation of *The Patient Choice Medical Imaging Act*, and define MRI services as per its supporting regulations.

The Prescription Drugs (Miscellaneous) Amendment Regulations, 2017

Amendments to the regulations allow for:

- The mandatory inclusion in the Pharmaceutical Information Program of data on exempted codeine products that are available for sale by pharmacists without a prescription.
- Allow for the automatic provision of seniors' benefits under the Seniors' Drug Plan for individuals covered under Saskatchewan Seniors' Income Plan (SIP) and Guaranteed Income Supplement (GIS) without an application by the beneficiary, and change the "age amount income threshold" from the federal to the provincial income threshold.
- Change the "child co-payment amount" and the "senior co-payment amount" from $15 to $25.
- Remove the requirement that a beneficiary who qualifies for the Saskatchewan Aids to Independent Living program (SAIL) must present a letter of approval to a pharmacy to receive benefits under the program.
- Repeal the section relating to the Saskatchewan Workers Health Benefit program which has been discontinued.

Appendix IX: Acronyms

AC	Appropriateness of Care. Find out more at http://hqc.sk.ca/improve-health-care-quality/appropriateness-of-care/
ALC	Alternate Level of Care patient. This patient does not require the intensity of services provided in the facility they are being treated in.
CAD	Coronary Artery Disease.
CDM-QIP	Chronic Disease Management-Quality Improvement Program.
COPD	Chronic obstructive pulmonary disease.
CQIP	Clinical Quality Improvement Program.
CT	Computed tomography scan. A type of digital image.
CTAS	Canadian Triage Acuity Scale. The Canadian Triage and Acuity Scale (CTAS) is a tool that enables emergency departments to prioritize patient care requirements and examine patient care processes, workload, and resource requirements relative to case mix and community needs These measures are defined by the Canadian Association of Emergency Physicians.
CWC	Choosing Wisely Canada.
EHR	Electronic Health Record. Find out more at www.ehealthsask.ca.
EMR	Electronic Medical Record. Find out more at www.sma.sk.ca.
FTE	Full Time Equivalent (Term used in Human Resources).
HKTRC	Regina Hip and Knee Treatment and Research Centre
HQC	The Health Quality Council works closely with Saskatchewan's health regions and Cancer Agency, the Ministry of Health, and health providers to make care better and safer for patients in this province. Find more information at hqc.sk.ca.
HIV	Human Immunodeficiency Virus.
IDR	Interdisciplinary rounds.
LINK	Leveraging Immediate Non-urgent Knowledge, a provincial telephone consultation service that gives family physicians quick access to specialists to consult on complex but non-urgent conditions.
LOCUS	Level of Care Utilization System:. An electronic client information system that assesses and matches level of care needs to existing services.
MAPLe	Score A tool used by health care professionals to prioritize clients' needs and to appropriately allocate home care resources and placement in long-term care facilities.
MRI	Magnetic resonance imaging. A type of digital image.
PHC	Primary Health Care. Find out more on page xx of this report and at saskatchewan.ca.
PQCC	Provincial Quality of Care Coordinators. The role of PQCCs is to aggregate, analyze, and report on critical incident data, and broadly disseminate applicable system improvement opportunities. PQCCs also provide advice and support to health regions and the SCA in their investigation and review of critical incidents.
RPT	Remote Presence Technology: An advanced telemedicine technology. It allows an expert health provider (physician, nurse, pharmacist, etc.) to be virtually "present" in the community to perform real-time assessments, diagnostics and patient management from a remote location, through either a mobile robot or a smaller portable hand-held device known as a "doc-in-a-box".
RHA	Regional health authority.
SACI	The Saskatchewan Medical Association's Appropriateness of Care Program.
SAIL	Saskatchewan Aids to Independent Living provides people with physical disabilities and certain chronic health conditions a basic level of coverage for disability related equipment, devices, products, and supplies in a cost effective and timely manner. Find more information at Saskatchewan.ca.
SA/STL	Safety Alert/Stop The Line.
SCA	The Saskatchewan Cancer Agency operates prevention and early detection programs, conducts innovative research and provides safe, patient and family centered care. Two locations: Saskatoon and Regina.

SDCL	Saskatchewan Disease Control Laboratory works to identify, respond to, and prevent illness and disease in the province. The lab provides reference testing, specialized screening and diagnostic testing. Find more information at Saskatchewan.ca.
SMA	Saskatchewan Medical Association.
SMS	Safety Management System.
Tertiary Care	Level of care that consists of complex procedures given in a health care center that has highly trained specialists and often advanced technology.
WNV	West Nile Virus.